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THE AMERICAN PRACTITIONER.

OCTOBER, 1879.

Certainly it is excellent discipline for an author to feel that he must say all that he has to say in the fewest possible words, or his reader is sure to skip them; and in the plainest possible words, or his reader will certainly misunderstand them. Generally, also, a downright fact may be told in a plain way; and we want downright facts at present more than anything else.—RUSKIN.

Original Communications.

ON THE EMPLOYMENT OF THE CATHETER.

SUGGESTIONS FOR OVERCOMING SOME OF THE DIFFICULTIES IN ITS USE.*

BY CHAS. C. F. GAY, M. D.

Surgeon to the Buffalo General Hospital.

Gentlemen: Your attention has lately been called to cases of retention of urine, in some of which you have been witnesses to difficulties arising in the employment of the male catheter. These several cases have suggested the propriety of speaking to you this morning concerning the methods by which some of these difficulties may be met and overcome. Ordinarily the passage of a catheter through a normal urethra is a simple process, requiring neither tact nor skill. Before the discovery of anesthesia, John Bell affirmed that the introduction of a catheter "is often the most difficult operation in surgery." "My conviction is," says Gross, "that few men perform the operation well."

Anesthesia, as you know, has, in many cases, made quite easy an operation, the performance of which was, before its

*A Clinical Lecture delivered at the Buffalo (N. Y.) General Hospital.

discovery, quite impracticable. With its use, however, you will encounter, in exceptional cases, trouble and perplexity enough to tax your patience to the utmost. Unless you have at your command the whole range of knowledge appertaining to the necessary manipulations, you will experience greater trepidation when, in the presence of friends, you approach your patient for the first time for the purpose of introducing the catheter than when, for the first time, you employ the obstetrical forceps in labor; indeed, your chances of success will be in favor of the latter. It is undoubtedly true, that the reputation of one surgeon has been lost and that of another made by success or failure in the use of the catheter.

Neither is it enough for you to know how to pass a catheter well. You should know also how to use the instrument so as not to abuse it. Infliction of pain is to be avoided. It is a reproach to affirm that the practice of the surgeon's art necessitates in every case the infliction of pain. Pain, as far as possible, is always to be avoided, whether in the amputation and dressing of a limb, repair of broken bones, or manipulations upon the urethra. I once saw a surgeon, who was about to use a catheter, grasp it in such a forcible manner with his whole hand, as to give one the impression that the instrument had to go through somewhere and somehow, regardless of consequences. If one had no anxiety, when witnessing rough manipulations, concerning the integrity of the urethral mucous membrane, his fears at least would certainly be excited for the safety of the instrument. You are not to handle the instrument as if it were a tamping-iron, nor manipulate the urethra as if it were, as Hamilton says, a rifle-bore. You are to bear in mind that the urethra is said to be a continuous closed valve (Thompson); that its size is conditioned by that of the penis (Otis); and you are to remember that the mucous membrane lining the urethral walls, with which your instrument comes in contact, is of extreme tenuity and sensibility; it has been likened in structure to the conjunctiva. Syncope may be induced by rapid entrance or withdrawal of the instrument, and chills and fever may occur from the same

cause. To introduce a catheter skillfully, often requires the utmost coolness and self-possession; should you lose either or both, you had better desist, for the time being, from making further trial, and wait until you regain possession of these faculties. On the whole, therefore, I regard this subject as not so elementary that teachers may pass it by in silence; nor has the time passed, nor yet come, when a well written monograph upon the subject of difficult catheterism would be misplaced in the hands of the general practitioner.

In 1857, Alban Goldsmith, M. D., published a small but valuable work upon Diseases of the Genito-Urinary Organs, which I can recommend you to study, in which the author gives some useful hints and directions upon the employment of the catheter. I early derived much advantage from reading this work, and if it be not out of print I advise you to procure a copy of it.

I am not to trouble you this morning with organic stricture cases. There are other obstructions besides strictures to prevent the easy passage of the catheter—such, for instance, as hypertrophy of the prostate gland, prostatitis, urethrismus, the triangular ligament, coagulated blood, muco-purulent discharge from cystitis and pyelitis, and tortuous and false passage, etc. Here is a patient I show you, a man past middle life, who has enjoyed good health until recently. He now finds himself unable to pass his urine, and therefore the employment of the catheter has become a necessity with him. He has albuminuria, and pus is also found deposited in his urine. He has pyelitis. At first the catheter could not be introduced unless anesthesia was induced, but we succeed at present without it. Every size, almost of both flexible and metallic catheters, was employed in vain; until at length the method which I show you was adopted, and has since been the only method employed to draw off this man's urine. You will observe that the instrument (a No. 10 silver catheter) is arrested about midway in the progress to the bladder. It seems to meet and does meet with some obstruction, and will go no further.

I now take a small glass syringe filled with glycerine, a quantity of which I inject into and through the catheter while it is *in situ*, and at the same time make gentle pressure upon the distal extremity of the instrument, which is observed to move forward. But it again meets with obstruction, and I again inject the glycerine, and, as you see, by repeating the injections three or four times while pressure is made, the instrument finally passes into the bladder without causing the patient the least degree of pain. Either glycerine, olive oil, or some mucilaginous fluid or even warm water, may be used for this purpose. The oil acts in a two fold manner, namely, as a dilating and lubricating agent. I have been equally successful in other cases with warm water, which has been injected with sufficient force to dilate the urethral caliber a short distance in front of the vesical extremity of the catheter and allow it to advance.

It would be foreign to my purpose to occupy your time in the discussion of questions relating to the pathological condition which made catheterism an absolute necessity. I merely direct attention to the fact of the presence of albumen and pus, and to the method of relief of the urinary retention, and leave the subject for your after reflection and study.

This case is quite unlike another which you have seen in the surgical ward, in whom the catheter was readily passed, but when passed, no urine escaped through it, simply because the eyelets of the instrument became filled and clogged with coagulated blood. The patient was in much distress on account of accumulation of urine in his bladder. Attempts had been made to draw off the urine previous to his coming into the hospital. Instruments of different sizes were now successively introduced into the bladder, and not a drop of urine obtained. A gum elastic catheter was next used, with the wire stylet long enough to reach the vesical extremity of the catheter. The wire was then made use of to break up the coagulum. So soon as this was done, the urine began to flow through it, the bladder was soon emptied, and there was afterward no further trouble.

I am reminded by this case of one wherein the patient had procured an instrument, and tried in vain to use it upon himself for retention following a debauch. He had made a false passage, and when called to him found that he had bled quite profusely during his futile attempts to draw off his own urine. I made several trials to catheterize him, but the instrument would invariably pass down near the neck of the bladder, through what I believed to be a false passage, and nothing but blood escaped. Had I employed force, the instrument would have passed out and beneath the bulbous portion of the urethra, and entered the bladder back of the prostate gland. This would have been followed probably by infiltration, septicemia, and death. I directed this man to stand up and try to pass urine, which he did after saying it would do no good, as he had stood up repeatedly and could not make a drop of water. But simultaneously with his straining to urinate, I withdrew the instrument, when, to the patient's surprise and comfort, he succeeded in evacuating his bladder.

If I am the first to make trial to draw off a man's urine, it annoys me exceedingly to find blood escaping. The instrument should always be used with such gentleness and care as to make it impossible to inflict sufficient injury upon the delicate mucous membrane as to cause the visible presence of blood. But you will sometimes encounter hemorrhage without abrasion of the mucous membrane, provided the prostate gland is enlarged and inflamed. In case of prostatitis, you will find the soft rubber catheter of service. To aid in its introduction, Dr. Otis has devised "a new prostatic guide," which I have not yet had occasion to use. Squire's vertebrated or prostatic catheter is an instrument so ingeniously contrived as to make a section of a metallic or silver catheter flexible. It is valuable in cases of enlarged prostate, and I commend it to you. You ought to be provided with these instruments. I do not find them, however, indispensable, since, with the finger in the rectum to direct the extremity, I rarely fail to pass the gum elastic catheter, without the stylet,

or silver catheter properly curved, whenever a large prostate exists.

Whenever tortuous or false passage is present, I have more often succeeded in passing a catheter after I had first passed a nickel-plated No. 12 to No. 24 metallic sound (English scale). This sound, if of the proper curve, will find its way into the bladder by its own weight. When, upon its removal, a silver catheter will also find its own way. I have, in many cases, relieved retention in this manner. Indeed it has become a fashion with me to try the sound first in many cases where any doubt exists in regard to the easy passage of the catheter. If the sound is not at hand, I try the largest silver catheter at my command. You will usually get on better with a large instrument; the beak of which is much less liable to be caught within the folds or lacunæ of the urethral walls. I use the virgin silver catheter whenever I can. It can be bent to any curve without breaking. I lubricate it with cosmoline; hold it loosely between the thumb and finger; pass it into the urethra till it reaches the arch of the pubes, when the handle ought to lie obliquely across the left groin. It is then to be gently raised toward a vertical position, and in a line with the body. The tip of the forefinger will now be sufficient to hold and guide it into the bladder. It may, however, be necessary to make slight pressure with the fingers of the left hand upon the perineum, or with the forefinger passed into the rectum.

You will find in your practice an occasional case of retention, to relieve which with the catheter will resist every effort you make, and exhaust every resource at your command, and then you are justified in making puncture of the bladder above the pubes or through the rectum. But in a case of this kind the catheter will still be of service, as I shall show you.

Some of you will remember the patient who came into the hospital some time ago with traumatic stricture. He had been kicked on the perineum, and was unable to void his urine. His bladder was much distended; he was suffering

greatly from desire and inability to urinate. Physicians had tried to pass the catheter before he came into the hospital, and undoubtedly false passage had been made by these repeated efforts. My house surgeon also made protracted trial to introduce an instrument. At my visit the patient was directed to be etherized, and when he was fully brought under the influence of the anesthetic, I tried and signally failed to pass even a filiform bougie. I made puncture through the rectum at once, using a long curved trocar and canula, in the following manner: The forefinger was introduced into the rectum, and the most salient portion of the bladder sought for. Guided by my finger, the trocar was passed along until its point reached the *vésical trigône*, where it was thrust through into the bladder, and this viscus evacuated The canula remained *in situ*. A small flexible catheter was now passed through it, and the canula withdrawn over the catheter, leaving the catheter in the bladder and retaining it there. For the next two days urine passed through the catheter, but soon after this time it was observed to pass in small quantity through the urethra. In another day, therefore, the instrument was removed, the urine continuing to pass by urethra; and in a few days the stream was of sufficient volume to allay further apprehensions, and the patient was discharged.

In this instance, I had good reason to prefer puncture through the rectum to aspiration above the pubes. I believe the operation is attended by very little risk, and have been led to regard the choice of this locality with much favor. The alternative of puncture through the rectum ought to be accepted and encountered rather than to run the greater risk of a too forcible employment of metallic instruments through a resisting urethra, with its concomitants of false passage and urethral fever; the former of which is easier to make than mend, and the latter easier to provoke than subdue.

Buffalo, N. Y.

DUCHENNE'S DISEASE.*

BY W. J. SCOTT, M. D.

L. B., male, aged forty-two years, has been complaining for three years; married; has not had syphilis. At first had pains in lower extremities; not much pain now. Appetite good; has control of excretions; the urine sometimes slow to start; bowels constipated. He has now palpitation of the heart; he feels a constriction around the chest and abdomen. You notice by his walk that locomotion is imperfect; and by the æsthesiometer that sensation is remarkably blunted; also by the ligamentum patellæ test that reflex impressions are almost entirely obliterated.

To understand these phenomena, we must take into account the anatomy of these sets of nerves. The function of the anterior and posterior sets are not only implicated, but the reflex sets. The afferent and efferent nerves (Marshall Hall's) are also involved to such extent that scarcely any response is made by them. If Dr. Murray crosses his legs, and the patellar ligament is tapped, you see how quickly you get the response on the muscles, so as to move the leg by such a jerk that he is unable to control it. Now make the same experiment with the patient, and there is no response.

What makes this difference? That depends on a pathological condition. The one is healthy; the other diseased.

There is yet another set of nerves involved in some of these phenomena. The sympathetic nerves become involved soon in the history of such a case. It is, I conceive, impossible to have any one set of these important nerves seriously diseased without the other becoming so, sooner or later.

I may with profit give a little of the history of this affection. It is called Duchenne's disease, because he first described it definitely. Afterward Trousseau described this condition clas-

* A Clinical Lecture delivered at St. Vincent's Hospital, Cleveland, Ohio, August 4, 1879. (Reported by Dr. Aesch.)

sically. But his description does not include the first stage of the disease, which I imagine is the important stage therapeutically—Duchenne's and Trousseau's description of sclerosis of the cord. But in all these cases there is an antecedent stage—hyperesthesia—in which the patient suffers the fulminating or lightning neuralgia pains, during which the patient is often treated for rheumatism without benefit. Thus as the sympathetic apparatus become implicated, he is treated for dyspepsia and liver complaint, with the same success. Thus he has heart troubles which need special attention, with no better success, unless the lesion is detected. Thus you see that often the lesion is not easily recognized in the first stage.

I believe most of the early cases mentioned depended on venereal excesses. Now we know that the cases often depend on other exciting causes, as long employment on railroads. Sometimes it may be questionable if both these may not have conjoined causes. In the first, however, the sensory function is the one affected more especially; and, on the other hand it will be the motor column which is first affected, then the other speedily follows, and we have the symptoms of sensory affection, and either or both will soon disturb the sympathetic and reflex functions, so that the pathology is complex and not easily followed by the beginner; yet with a knowledge of the anatomy the description is not very abstruse, but without this knowledge you can not understand it.

The therapeutics are not promising. If you refer to Trousseau, you will see that his medication amounts to nothing; nor will yours if you do not recognize the disease in the stage before his description begins. He describes our case here well (as sclerosis), and the sulphur-bath treatment may be as good as any. In this stage the disease is a progressive one. Some points are in a stage of chronic inflammation, with gradual exudation occurring, while others are more acutely affected, and in this way the indications for treatment can not be well met. I apprehend, for this reason, that all plans of treatment are so unsuccessful in results.

Electricity is recommended by good men as the remedy

even in this stage. What has experience shown? In the majority of cases the application does more harm than good. The interrupted current, in my observation, has always done harm; so that in the hands of people who give electricity for all kinds of diseases with giggling machines, and give it in such a way as to jerk the joints out of place and find the tender spots, always does harm. Often I have seen people treated in this way to their detriment, and this by persons who say that they have studied the subject and know all about it, and the man who would not use it in nervous diseases is not up to the times. Oh, yes, would you expect such advantage during the hyperesthetic stage? Not by any means. Then during the anesthetic stage with exudation, you need not expect much from this agent. If applied at all, the interrupted current should be used and applied with moderate intensity. Sometimes, when the muscles become atrophied for want of nerve influence, by applying the interrupted current to them in such a way as to produce contraction, advantage may be gained to the nutrition of the parts affected. But when all the ganglia along the spine and into the brain become hyperesthetic, as they are in the first stage, it is not strange that a peculiar set of symptoms should manifest themselves, and give plain indications for treatment when correctly interpreted. And again when these same ganglia become anesthetic from perverted or imperfect nutrition, or by subacute inflammatory processes with exudation, it is not strange that a different class of symptoms should present themselves, and other indications should be present for therapeutic management. Without this distinction in the pathological condition, the therapeutic application will necessarily be illy done. How often are these distinctions made? Sometimes it is not easy to make them, or to tell where one ends and the other begins. Indeed, in the very nature of the affection, to some extent they are both present.

Lately we have had some new terms introduced in this class of diseases—not so much in this as in others similar in some respects. For some affections of women, we often see the

term neurasthenia, meaning want of nerve power, from its derivation. Then we should have another, meaning the opposite, as neurosthenia. Now I doubt whether these terms convey so full and exact a meaning as the others to the man who can see the force of their derivatives. We are all acquainted with the meaning of esthesia and anesthesia.

The indications for treatment in the hyperesthetic condition is to reduce the congestion, to diminish sensibility, and as far as possible prevent exudation; and, if this is possible, to prevent the second stage.

Now you take the class of remedies which will accomplish this best, and clinical experience will show that you do most for the patient. What are these? At the head of this class stand the bromides of potassium, sodium, lithium and ammonium — the potassium bromide being the best. The effect of these may be assisted by digitalis, belladonna, hyoscyamus, and ergot. But when the ganglia cease to be sensitive, and there is some exudation, then it seems to me that potassium iodide, with one of the others, will fulfill the indication best; for it acts better as a detergent in producing absorption of foreign material, while the others act on the sympathetic more directly. And when the anesthetic stage has fully occurred, we use with advantage the more direct nerve stimulants and nutrients, with counter-irritants. The therapeutics of these conditions should be governed by the pathological condition, if we expect to benefit the patient by medication. But how will the practitioner do this if he has not the pathological knowledge? I hope that I have impressed these ideas on you in such a way as that you will remember them, and see that this is not a theoretical view of the subject. The early use of electricity, or indeed the use of it at any stage, unless done on pathological principles, is followed by bad results. The treatment by hot baths or by cold douches has not been followed by good results. Indeed, we would not expect them to be followed by benefit unless applied with skill, precaution, and knowledge of the conditions which are often overlooked, or not possessed by those using these agents.

These questions in therapeutics apply equally to all conditions of the cord, whether the principal part of the lesion be in the posterior, anterior or lateral columns of the cord. The symptoms may differ materially, but if you interpret them by function, you will readily see that precisely the same pathological condition ought to be present, and consequently the same rules of practice will apply in these cases.

The mineral waters have been recommended in these cases, but the use of them has not been successful in relieving the disease. No set course of practice can be depended upon in a number of cases, for the reason that each case must be studied and then treated from the indications present. I have relieved many of these cases greatly upon this plan of treatment:—First discontinuing absolutely any exciting or predisposing cause, and then giving the remedies I have indicated, according to the conditions developed.

CLEVELAND, OHIO.

FATAL PUERPERAL CONVULSIONS.

BY WILLIAM L. WHITTED, M. D.

On March 24, 1879, I was called in haste to visit Mrs. A., who was in the ninth month of pregnancy, and laboring under a severe attack of convulsions. She was a tall lady, nervous-lymphatic temperament, fair skin, blue eyes and light hair, about twenty-one years of age, the mother of two children. After her first labor, about three years ago, she had severe convulsions, during the ninth and last paroxysm of which her attending physician, I learn, pronounced the case hopeless, but after a long sleep she became conscious and began to improve. I attended her during her second labor, which passed off without any untoward symptoms, and she was well in a short time. She had had two or three very hard convulsions before I arrived. The paroxysms were followed by a deep

sleep, characterized by stertorous respiration. These sleeps were succeeded with nausea and efforts at vomiting. When she became sufficiently conscious to speak she complained of great blindness. She had but two paroxysms after my arrival. I administered hypodermically one fourth of a grain of morphia, and followed it shortly with an injection, per rectum, of bromide of potash and chloral, one drachm of each. She slept soundly for several hours, and the disposition to convulsion abated; but the severe cephalalgia remained, accompanied with amaurosis. She was annoyed with these symptoms more or less, especially at night, up to the morning of the seventh day of April, when I was called to attend her in her confinement.

The patient's pulse during this time ranged from sixty to eighty, rather oppressed, face flushed, pupils dilated, respiration normal. I found vertex presentation, the head low down in the pelvis, the os dilated to the size of a half dollar, and the pains of labor recurring regularly. The child was delivered in two hours after my arrival, and the placenta followed soon after. I congratulated myself that the crisis was over without the dreaded convulsion; but in this I was disappointed.

About three o'clock on the following morning I was called again to see her, as she had had another slight convulsion. I found her rational but rather stupid, and still complaining with severe headache and blindness. I left a prescription of bromide of potash and chloral, which had succeeded before. I was sent for again at one o'clock in great haste—the messenger stating that she had a convulsion at nine o'clock, and another at twelve o'clock, when they sent for me. I found her apparently *in articulo mortis*. The convulsion had lasted, with slight remissions, for three-quarters of an hour. The face, hands, and fingers were livid; I could feel no pulse; pupils dilated. I let her inhale a small amount of chloroform, and a slight improvement was manifested. When a disposition to a return was apparent, the chloroform in small quantity was reapplied, and this had the effect to stay them. But

the circulation was still unimproved, and dissolution seemed imminent. I thought I might improve the circulation by giving hypodermically one-fourth of a grain of morphia with atropia in small dose, which I at once administered. In a short time the lividity began to abate, and the capillary circulation at least was improved, yet the radial pulse was imperceptible. The carotid beat at the rate of one hundred and forty to the minute. A deep comatose sleep succeeded, with slow, heavy, stertorous respiration of eight or ten to the minute.

As soon after the convulsions had ceased as possible, I introduced my hand into the vagina and removed quite a quantity of clotted blood, which filled the vagina and os uteri. This done I introduced a catheter and drew off about a pint of urine. The temperature of the body gradually rose, and the surface heat was considerable; the pupils were moderately contracted. In the course of three or four hours the respiration became more frequent and more natural, but the condition of the pulse remained the same—the head hot and the carotids bounding. I sponged the head with cold water, and administered tincture of aconite and tincture of digitalis in small and frequent doses. Small quantities of cold water, and occasionally milk, were administered with a spoon.

I remained all night with her, but her condition was much the same on the following morning, save that she could be aroused sufficiently to open her eyes and groan, and utter a few words, yet she seemed entirely unconscious. The breathing was more natural and easy, the circulation some slower, yet the radial pulse was but faintly perceptible—very much in the same condition as when I first saw her on the day previous. I again introduced the catheter and drew off about one quart of urine.

I called again at eleven o'clock; found her breathing much easier, more natural and more easily aroused—quite the same. I had the vagina well cleansed with warm water, clean linen put upon her body and bed, and everything arranged for the welfare of the patient that could be. Her tongue was moist,

the skin moist and more natural to the touch, and she would swallow water, medicine or nutriment, when put to her lips. The countenance wore a more natural expression, and the capillary circulation in the face was good as well as the hands, yet under the finger-nails the lividity remained to some extent. The feet were warm, and from every indication, save one, there seemed room for hope. The action of the heart was much the same—at all events had made no improvement. I tried a little brandy, but fancied it did no good. I had prepared for her some beef essence, and administered this with cream every two hours, and still continued the digitalis without the aconite. I also gave her, for the purpose of giving tone to the nervous system and improving the functions of the spinal and ganglionic nerve centers, the following:

℞ Quiniæ sulph, ... gr. xv.
Fluid ext. ergotæ, ... ʒ iij
Fluid ext. belladonnæ, ... ʒ ss. M.

Of this I directed a teaspoonful be given the patient every three hours. I remained with her about two hours, and before I left I noticed that her respirations were interrupted with frequent sighings or long inspirations. I was now led to believe that some grave lesion of the base of the brain existed. I left her with instructions to give me information if any change of importance took place.

In about four hours from that time I was informed that she was again breathing slow and hard, with the same stertorous sound which took place after the convulsions. I now abandoned all hope. I went to see her on the following morning early, and, as I expected, found her dying. She died by apnea, the heart beating several beats, full and strong, for thirty seconds after respiration had ceased.

In reflecting upon this case, I am led to ask the question as to the character of the convulsions. Were they uremic? The muscular system was not agitated as greatly as I have generally seen in puerperal convulsions, but partook more of the epileptic character. The amaurosis which supervened

upon the first attack, and the persistent cephalalgia, with the final apoplectic coma which followed in the wake of the last terrible convulsion, impressed me with the belief that uremic toxemia was the cause.

ELLETTSVILLE, IND.

REMARKABLE DERMOID OVARIAN CYST, WITH BILIARY CALCULI, ETC.*

BY R. M. DELZELL, M. D.

Mrs. Mary J. High, wife of Nathaniel High, White county, Ind., married at the age of twenty-one years, gave birth to six children within ten years. Health good during her child-bearing period, and for fifteen years afterwards. During the latter period menstruated regularly, and weighed on an average two hundred pounds. At the age of forty-seven, while riding in a hack, she received a jolt which caused pain and inflammation in the lower abdominal region. From this time she was never well. She applied successively to Drs. Potter and Martz, of Hamilton, Ohio; Dr. Mussey, of Cincinnati; Dr. Kümbler, of Seven Mile, Ohio; Drs. Strother and Washburn, of Lafayette, Ind.; Drs. Hood and Patton, of Remington, Ind.; Drs. Didlake and Grant, of Walcott, Ind., who respectively diagnosed and treated her for "false conception," "derangement of the liver," "liver disease," "general derangement," etc. At the age of fifty-six she died.

I learn from her husband that during her ten years' decline, she almost always had pain in the abdomen, especially in the right iliac and pelvic regions. She said "her intestines had grown fast;" had pain in her back and shoulders; had frequent attacks of "bilious colic;" had "spells" so severe that she would become semi-unconscious and froth at the mouth,

*Read before the District Medical Society of White, Newton, Jasper and Benton Counties, Ind. (Published by request of the Society.)

and would fall down if not supported. These spells always began with the colic, which came on very suddenly. Had to pass water very frequently, and in small quantities. Suffered much with headache and constipation. During the last few months became much bloated—first in her feet and legs, then the mischief became general. The dropsical symptoms became so marked that the trocar was twice used, but without "getting water." It was thought by some of her late attendants that there must be fluid in the abdomen, but that it was enclosed in cysts. Her great corpulence and the amount of infiltration made a diagnosis very difficult.

I saw her for the first time on the evening she died, and with Dr. M. T. Didlake, of Walcott, made a post mortem examination, at which the following facts were ascertained: We found the abdominal walls very thick, much infiltrated with fluid, and studded with masses of soft, gelatinous, lead-colored matter. The intestines were firmly adhered to the abdominal walls in the right iliac region. The anterior surface of the bladder was firmly adhered anteriorly, and its capacity much lessened. The liver was enlarged to near twice its normal size. The gall bladder was full but not distended; its walls thickened, containing two calculi—one as large as a quail's egg, the other one-fourth as large. The surfaces where the calculi were in apposition were worn smooth as glass by their long friction upon each other; and from several similar facets on these we conclude that numerous other calculi have existed there, but had been discharged. The uterus was very solid, and the uterine canal entirely obliterated. The right ovary was normal, and the fallopian tubes injected. The left ovary had degenerated into a dermoid cyst about the size of a ten year old boy's head. The walls of the cyst were thin, and well supplied with blood vessels. The cyst was filled with a mass of semi-fluid, grayish matter, and a large quantity of detached hair. Near the base of the tumor was quite a patch of dermal tissue, out of which grew some small hairs. Adipose matter was abundant throughout the abdominal cavity.

Our theory in regard to the cyst is that there had been an ovarian conception, and this dermal tissue was the result, and that for years it had been growing and casting off the hair with which it was partly filled. I give the history of this case at some length, on account of the difficulties that so often defy and render futile our attempts at a diagnosis, and recommend more thorough examination into the pathological possibilities that may be mingled with some two hundred pounds of humanity. The uterus and its appendages, including the cyst and its contents, the gall-bladder and the calculi, were exhibited to the Society, and the case discussed. The specimens are now in my possession.

NOTE.—The names of physicians who had attended Mrs. High, as well as her own name, are inserted in full at the request of her husband, so that should this report fall into their hands in your Journal, they will probably remember the case. R. M. D.

REYNOLDS, IND.

SPONTANEOUS AMPUTATION OF THE SHOULDER-JOINT.

BY JAMES I. ROOKER, M. D.

I am indebted to the patient and his father for the facts in the following case, which go to show what nature can sometimes do when left to herself:

At the age of fourteen, A. K. W., some fourteen years ago fractured his forearm near the lower part of the middle third. The fracture was reduced by Dr. L. S. Campbell, the family physician. On the evening of the second day there was slight delirium, with incipient gangrene below the seat of the fracture, and inflammation extending to the elbow. On the following morning the arm was swollen to the shoulder. The attending physician, in consultation with others, determined not to amputate, owing to the increasing gangrene. The line of demarkation forming about the fifth day extended to the

spine of the scapula, laying bare the bone and exposing the acromion process, and involving the pectoral muscles.

In about two weeks after the consultation mentioned above, another consultation was held, and it was again decided to let nature continue her work. The condition of the poor boy at this date was deplorable; the discharges from the decomposing arm were profuse, and so poisoned the atmosphere of his room that it became unbearable. Wearied of his continued and intense suffering the patient courted death, and at his own request his coffin and burial clothes were purchased and placed within his room. The bones which were exposed soon exfoliated — the spine of the scapula and the acromial extremity of the clavicle coming away.

The annexed woodcut, taken from a photograph kindly furnished me by Mr. W. on the first of August last, will give a very good idea of the extent of injury, although it occurred over fourteen years ago. There is but a small amount of the body of the scapula remaining, the integuments being closely connected to it; the healing process soon covered up the exposed surfaces. Entire recovery was effected in about three months from the date of fracture.

In closing this report, I may say that the father of the young man now resides at Zionsville, Boone county, Ind., and the patient at Carmel, Ind., where the fracture and treatment occurred in October, 1865. He is at present a member

of the junior class of Purdue University, and bids fair to live a long and useful life; and for all these things he is certainly but little indebted to the doctors.

NOBLESVILLE, IND.

LECTURES ON THE SURGERY OF THE FACE.*

BY FRANCIS MASON, F. R. C. S.

Surgeon and Lecturer on Anatomy at St. Thomas's Hospital; Hon. Fellow of King's College, London.

LECTURE II.—PART II.

Fracture of Lower Jaw.—Fracture of the lower jaw most usually occurs between the lateral incisor and the canine teeth, this situation being perhaps the weakest part of the bone. The inferior maxilla may, however, be broken in other situations—at the symphysis, the angle, or at the neck of the condyle. An interesting case, from a diagnostic point of view, in which the neck of the condyle was fractured, is recorded by Mr. T. Holmes. In this example there was displacement of the lower fragment into the meatus auditorius externus, with serous discharge from the ear. The case was interesting, as showing the source from which the sero-sanguineous discharge may come, whether it may depend on a fracture at the base of the skull, or whether merely from a fracture of the external auditory meatus.

Fracture of the neck of the jaw by *contre-coup* is still more rare, yet such a case has been described by Dr. Cockburn, of the Royal Engineers. The injury was caused by a blow of the fist, received at the left side of the face. The least attempt to open the mouth caused much pain at a point close to the tragus of the right ear. It was easy to guess the nature of the injury, and it required but little manipulation to detect a

* Delivered at the Medical Society of London, January, 1878.

simple fracture of the condyloid process of the right side, at a point very close to the insertion of the external pterygoid muscle. The fracture was put up in the usual manner, with a splint of gutta percha molded to the lower jaw, the usual chin-sling bandage, with a piece of cork between the teeth. The case did perfectly well.

Fractures of the lower jaw, as a rule, unite most perfectly, and however great the primary displacement may be, experience proves that the muscles resume their harmonious action, and in the end a most satisfactory result is obtained. In some instances, however, the bones unite very irregularly: thus, in a case of this kind, Mr. Bickersteth, of Liverpool, had to divide the bone with a saw, and then nailed the parts together with small brass pins.

The plan of fastening the broken ends together with wire passed over the teeth is of ancient date, but the wire so placed is very apt to slip. Mr. Thomas, of Liverpool, speaks highly of a plan he has successfully adopted of boring a hole with a drill on each side about a quarter of an inch from the fracture. Through these holes a wire is passed, and twisted in the form of a coil. The immediate effect in one case was that from the first day the patient expressed himself as able to use the jaw.

Another plan is that practiced by Mr. Wheelhouse, of Leeds, and represented in the diagram I show you. Two holes are bored with a drill through the substance of the jaw-bone, one on either side of the fracture. Through these holes two pins, having flat, circular, and perforated heads, are passed from behind forwards, and their points bent in opposite directions. The perforated heads are then threaded with a good stout silk ligature, which is brought forward over the teeth, and a figure-of-8 suture made round the reversed ends of the pins. Mr. Wheelhouse informs me that he has adopted this plan in one other case with success.

And, lastly, although I have not yet had an opportunity of testing it, I take the liberty of referring to a simple plan of uniting broken bones, which I successfully employed in 1871,

in a case of ununited fracture of both bones of the forearm, an account of which is published in the Medico-Chirurgical Transactions. This method might, I venture to think, be advantageously used in suitable cases of fracture of the lower jaw. Its principle is well illustrated in the woodcut (Fig. 1), which represents it as applied to one of the bones of the forearm. It will be perceived that it is nothing more than the twisted suture, and that by withdrawing the needle the wire or thread is of course released. In adopting this method I imagine that the risk of damaging the bone is very slight.

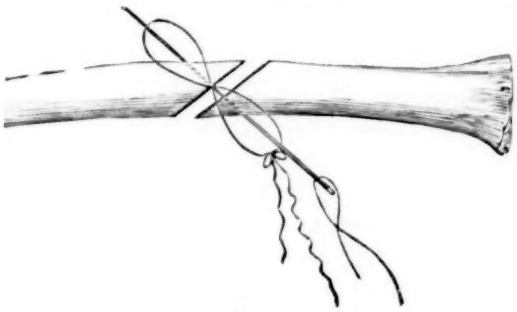

FIG. 1.

Mechanical apparatus for keeping the fragments together have been suggested by Mr. James Salter, by Mr. Gunning, Mr. Berkeley Hill, Mr. Moon, and by others.

In those rare examples in which bony union fails to take place there is abundant scope for ingenuity on the part of surgeons practicing dental surgery. Thus, Mr. Napier has furnished me with the particulars of a case of ununited fracture of the lower jaw which was sent to him by the late Sir William Fergusson, in August, 1867. The patient had been frightfully wounded during the siege of Lucknow, and besides having the lower jaw fractured in three places, had also a large portion of the superior maxilla carried away by a cannon-ball. Exfoliation to a considerable extent took place in the lower jaw, which, together with the loss of many teeth, caused an ugly and inconvenient contraction. There was no bony union whatever, but Mr. Napier so constructed an apparatus as to completely restore the power of mastication.

Permanent Closure of the Jaws..—In all cases of permanent closure of the jaws in which the lower jaw is fixed by cicatrices, whether caused by injury or by disease, the mere division of the cicatricial band is seldom sufficient to effect a complete cure, for the wound heals rapidly, and the cicatrix, as a rule, becomes even more dense than before. In operating on such cases, Mr. Callender suggests that after the free division of the cicatrix a portion of the alveolar border, together with the teeth, should be removed.

The division of the masseter muscles has been adopted in certain cases, both subcutaneously and by a submucous method through the mouth. The operations that meet with most favor at the present day are, first, that proposed by Rizzoli, of Bologna, in which the bone is simply divided; and, second, that practiced by Esmarch, which consists in removing a portion of bone. Esmarch's operation has been performed by Mr. Mitchell Henry, Mr. Barnard Holt, Mr. Heath, Mr. Lawson, Mr. MacCormac, M. Richet, by myself, and other surgeons. Most of these cases have been published, and I therefore need not detain you further than by saying that the operations were undertaken either on account of a dense cicatrix existing between the jaw and the cheek, the result of injury or disease, or for anchylosis of the temporo-maxillary articulation. The case on which I operated belonged to the latter class, and the joint on one side only was affected. The patient was a woman aged twenty-nine, who thirteen years previously had scarlet fever. Abscesses formed in the temporo-maxillary region, and she recovered with fixed jaws. A horizontal incision was made, about two inches in length, in the soft parts under the body of the jaw on the right side; the soft tissues were then separated from the bone, and an opening made into the mouth between the teeth and the cheek. A narrow saw was applied vertically in the space between the first and second bicuspid teeth, and the bone divided with the help of the cutting forceps. After this section the left side of the jaw was found to be freely movable, but the right side was firmly fixed. A piece of bone

nearly an inch in length was then removed from the right or anchylosed side. There was no hemorrhage worthy of remark, and the wound was closed with silk sutures. She unfortunately had an attack of erysipelas which retarded her progress considerably, but the result was that when she left the hospital she could open her mouth for about three-quarters of an inch.

Dr. Maas relates a case in which there was bilateral anchylosis of the jaw. The patient was a man aged twenty-seven, who had scarlet fever when he was seven years old, and since the age of ten he had not been able to move the jaw at all. The secondary dentition was attended with great difficulty in the removal of the milk teeth, and the new teeth were for the most part displaced laterally. Herr Middledorpf operated on the right side, according to Esmarch's plan, with good result, and Dr. Fischer about four months after operated on the left side with great improvement.

It is seldom that an opportunity is afforded of examining the pathological condition of the parts after operation, but M. Boinet reports one such example. The patient was a little girl who had immobility of the lower jaw following gangrene of the mouth. Rizzoli's operation was performed, and matters appeared at first to go on well, but at the end of three months the divided portions began to unite, and in eight months there was complete consolidation. M. Boinet then performed Esmarch's operation, removing a wedge-shaped piece of bone, with the base at the lower border of the jaw and the apex at the alveolar ridge. The operation was performed in June, 1863, and six weeks or two months afterward the patient could eat any kind of solid food. In the beginning of September, 1866, she died of phthisis, having up to the time of her death retained the mobility of the jaw. On examining the bone, it was found that there was a false joint between the divided portions, and there was an arrest of development of the bone and atrophy of the muscles inserted into it.

Foreign Bodies in the Nose and Ears.—Foreign bodies, such

as cherry-stones, locust-beans, brass rings, slate pencils, buttons, screws, pieces of wood, peas, etc., are not infrequently met with in the aural and nasal cavities of children, and even in adults. Such substances have been known to remain in one or other of these cavities for wellnigh a lifetime, causing little or no inconvenience. Thus a case is related of a lady from whose nostril a foreign body was dislodged during the act of sneezing; it was found to be a button which had belonged to her little brother when they were both infants. Another case is recorded in which a piece of slate pencil was removed from a woman's ear, which had been put there when she was at school "forty years before." And a third instance, a patient of Mr. Winterbotham's, of Cheltenham, in which a cherry-stone had been in the ear for sixty years. Mr. Hargood, of Eastbourne, also recently reported the case of a gentleman, aged forty-one, from whose ear a piece of cedar wood was removed by syringing. "The patient remembered distinctly the fact of its introduction when he was a boy at school, at least thirty years before. No attempt had been made to extract it, and its presence had not troubled him until now."

It occasionally happens, however, that a good deal of inflammatory action is set up by the foreign body. As a case in point, I may mention that of a girl who was under my care at the hospital, and who was admitted on account of having a small stone in her ear. She subsequently had paralysis of the facial nerve. Mr. Jonathan Hutchinson alludes to the case of a child who not only had facial palsy, but died of meningitis caused by the presence of a locust-bean in the ear.

There are various instruments employed for removing foreign bodies from the ear, each good in its way. A loop of wire, a scoop, or a needle with the point just slightly turned up, forceps, or an instrument such as this I now show you—which is the best—may be used.

It is not always easy to detect the exact character of the foreign body, and as bearing on this point I may incidentally refer to the case of the man who is here this evening in the

adjoining room. About fifteen months ago he was accidentally shot behind the left ear. The patient was seen by my friend, Mr. Henry Jacobs, of Kensington, who has given me the opportunity of examining him with reference to the lodgment or not of the bullet, for the latter could not be discovered after the accident. There is a constant discharge from the ear, and, as you will observe, well-marked facial palsy. My colleague, Dr. Stone, has kindly constructed a clever electrical apparatus by which we are enabled to detect the unquestionable presence of the bullet. Dr. Stone has done us the honor to be present, and I think you will agree that the Society is much indebted to him for the trouble he has taken in bringing the apparatus here, and of thus giving the Fellows the opportunity of witnessing so interesting an experiment.

[The apparatus constructed by Dr. Stone consisted of two fine pieces of silver wire, covered with silk, which were wound together in a single strand to imitate a probe, and about three inches in length. The whole was insulated and stiffened with shellac, the ends being left loose for connection with a battery and galvanometer. The joined ends at the opposite extremity were cut, so as to leave two little disks of clean silver. On placing these disks in contact with the foreign body in the ear, the galvanometer was visibly deflected, indicating the presence of a metallic substance, which was assumed to be the bullet. The exposed surfaces of the disks were intentionally kept as small and the insulation as perfect as possible, to prevent the transmission of a perceptible current by the fluids of the sinus.]

Living larvæ have been found in the meatus of the ear. Dr. Routh publishes such a case. The patient was a gentleman who three years before was tormented with a fly near his ear. Convulsions followed the presence of the larvæ, but the patient recovered, although he remained deaf. Dr. Blake, of Boston, has seen four such cases.

Dr. Kealy, of Gosport, reports a case to show the curious course taken by a pin that had been introduced into the external meatus. It passed through the middle ear, probably

along the Eustachian tube, and was extracted by the patient from her throat by hooking it with her finger.

In dealing with foreign bodies situated in the external auditory meatus, syringing the passage will often suffice to effect removal, but in many cases forceps and other instruments must be used, yet they should be employed with the greatest caution. As a rule, if left alone, the foreign body becomes loose, and falls out on the pillow as the patient lies in bed. In extracting foreign bodies from the ear, M. Debout has recommended that the mouth of the patient should at the same time be kept open. It is sufficient, he remarks, to introduce the end of one's finger (and the Fellows may try it on their own person) into the external auditory canal, and to make the lower jaw move, in order to become convinced of the enlargement that the canal undergoes each time the condyle of the jaw is made to move. Dr. Voltilini offers some very sensible and practical remarks on this subject, which I venture to quote. He says, "The first thing we have to do is to assure ourselves that a foreign body is really in the ear, for it by no means rarely happens that persons apply to the surgeon under the belief that an insect or other substance is present, but which a more exact inspection fails to discover." He adds we should never employ force, and in saying this he did not wish to convey the idea that foreign bodies should always be left in the ear, but that matters should not be made worse by violent manipulations. Still more recently, Mr. Dalby has laid down a very practical law that no attempt should be made to remove a foreign body from the ear unless the auditory canal be thoroughly illuminated. Where this rule is broken, the tympanic membrane will most probably be ruptured, and thus the life of the patient placed in imminent peril.

Foreign Bodies in the Orbit and Face.—The limits of my time prevent me from entering into the different injuries of the orbit and its contents, and I regret this the more inasmuch as wounds in the neighborhood of the eye frequently give rise to various anomalous symptoms. In fencing the

foil has occasionally passed straight through the orbit, and has penetrated the brain, in some cases, even without injuring the globe of the eye.

The specimen on the table, taken from the museum of St. Thomas's Hospital, is one of great interest, as illustrating the curious course taken by a portion of a table-knife, which entered the cavity of the skull through the orbit. A girl was mixing some detonating powder with a large table-knife. An explosion took place, and she was severely burnt about the face, for which she was admitted into St. Thomas's Hospital. A part of the knife could not be discovered in the room in which the accident occurred. The girl died about a week after admission, and at the post mortem examination the missing portion was found in the position you now see it placed, vertically between the vertex and base of the cranial cavity.

Mr. George Lawson has placed on record an interesting account of the lodgment of a large piece of stick in the orbit itself, accompanied with paralysis of all the muscles of the orbit; and I may refer to a somewhat remarkable case that was under the observation of Mr. Furneaux Jordan. "A man, who was employed in threshing, became the subject of severe ophthalmia. At the expiration of several weeks the patient, whilst pressing his finger on the lower eyelid, suddenly ejected from a comfortable bed of warm pus a grain of wheat, which had shot forth a vigorous green sprout." Foreign bodies will remain imbedded in the face for days, months or years, without giving rise to any discomfort. Thus I not long ago removed from a gentleman's face eight or ten shot, which had caused no inconvenience whatever for twelve years. Substances of different kinds are occasionally found imbedded in various parts of the face without the patient being at all aware of their presence.

In 1868 I saw a man, aged forty-two, at the Westminster Hospital, who had a swelling on the lower lip on the left side. He had been told he had cancer, and sought advice on that account. It appeared that he had fallen from a scaffolding

two or three months previously, and had sustained considerable injury to his scalp and face, and his lower jaw was fractured. He had been a patient elsewhere, and stated that when he was under treatment he had fits. On examining the part, the lip was found a good deal swollen, and rather tender to the touch. I made a puncture, when the knife impinged on a hard substance, which proved to be a portion of the crown of the left lateral incisor of the lower jaw, which the patient said he missed after the accident. It was decayed at the neck, and had sharp edges. The patient made a good recovery.

Another instance is recorded in which a canine tooth was lodged in the thickness of the lower lip simulating a cancerous tumor. The patient was a lady forty years of age, who had always suffered with her teeth, and had but few incisors left, the rest of the jaws presenting roots more or less firmly wedged, and the alveoli more or less decayed. Towards the end of the year 1854 she felt a small tumor forming in the lower lip of the left side. Pain was subsequently experienced, and a few months afterwards the patient could hardly eat. She sent for her medical attendant, who made a crucial incision, and discovered a long root of the canine tooth which had been imbedded in the substance of the lip.

Another case is related by Mr. W. H. Folker, at the North Staffordshire Infirmary. The patient was sixteen years of age, a joiner, and was admitted August 29, 1867, on account of a tumor existing in the substance of the upper lip. The swelling was on the right side of the mesial line corresponding to the right central incisor tooth (which was noticed to be wanting), and it seemed to be formed by hypertrophied lip. It caused a good deal of deformity, as the patient was unable accurately to close his lips. The tumor felt hard, but was not painful. On carefully examining the swelling, a small aperture was perceived at its base; and on passing a fine probe a hard substance was felt, which was diagnosed to be a tooth. On the 31st of August, an incision having been made through

the tumor, a tooth was found at its base. After its removal the swelling disappeared, and the patient was discharged on the following day.

Mr. Haynes Walton has reported a case of a patient, aged thirty-five, who, three years and a half before, had a fall, and lost his right upper lateral incisor. He had much pain, and a few weeks later an abscess formed, which discharged through a small opening in the cheek as well as through the alveolus of a lost tooth. Then another abscess formed, leaving a sinus open in the right cheek. On probing this, a hard substance was found. The wound was opened up, and a perfect incisor tooth, lying loose in the antrum, was removed.

In conclusion, I will refer to an interesting case that was under the care of Dr. George Johnson, in which tetanus, with facial neuralgia and palsy, and a recurrence of epilepsy, were excited by a foreign body imbedded in the cheek. The patient was a wheelwright, aged forty-four, who, on July 4, 1872, was cut on the cheek by a blow from an iron axle that fell upon his face. The wound was strapped up by a chemist, and healed, but remained very painful. On the 12th he had an epileptic fit. In early life he had been subject to epilepsy, but until the occasion mentioned had been free from fits for twelve years. On the morning of the 13th—that is, about ten days after the accident—he had difficulty in opening his mouth. The left masseter muscle felt prominently hard and rigid. There was a scar, about three-fourths of an inch long, an inch below the left eye, the cicatrix being hard and very tender to the touch. Dr. Johnson, believing that there was a foreign body present, directed the house surgeon to cut through the cicatrix, when a sharp, angular piece of flint, nearly as large as a grain of wheat, was discovered and removed. With this the symptoms gradually passed away. The chief interest of the case, as Dr. Johnson remarked, consisted in the fact that formidable nervous symptoms were excited by the presence of a foreign body of small size beneath the cicatrix of a recently healed wound.

Reviews.

Transactions of the American Gynecological Society for the Year 1878. Volume III. Boston: Houghton, Osgood and Co. The Riverside Press, Cambridge. 1879. 472 pp.

This vigorous society held its third annual meeting in Philadelphia, September 25th to 27th, 1878, with an attendance of twenty-seven out of a total of forty-five Fellows, and a list of twenty-five invited guests, privileged to participate in all discussions during the session. The death of President Peaslee devolved the duty of presiding on Vice-President Goodell at this meeting. Dr. T. G. Thomas, of New York, was elected President for the ensuing year, Dr. J. R. Chadwick, of Boston, was continued secretary, and the next meeting is to be held in Baltimore, beginning Wednesday, September 17, 1879. Twenty-two papers were presented to the society, and of these fourteen were read entire and discussed; the remaining eight, for want of time, were read by title only, but appear in full in the volume before us.

"The relation of Neurasthenia to Diseases of the Womb," is the title of the President's address, by William Goodell, A. M., M. D., of Philadelphia. After a brief warm tribute to the memory of Dr. E. R. Peaslee and Dr. W. L. Atlee, two Fellows who died since the last annual meeting of the society, Dr. Goodell gives hearty thanks to Surgeon Billings for the complete bibliography of obstetric literature attached to the second volume of the Transactions, and commends Secretary Chadwick for the satisfactory manner in which the Transactions were issued, but lamenting the lateness of their appearance, attributing this, no doubt justly, to tardy contributors and laggard author proof-readers. It is high time all societies that issue books of transactions should adopt a rule making a

short limit to waiting for promised papers, in the original or in proof, and their rigidly enforcing the rule against all men.

Dr. Goodell suggests that the scope of the society be enlarged so as to embrace the diseases of childhood among the subjects to be considered, and also certain social questions, such as dress, sexual excess, criminal abortion, etc. Having disposed of these preliminary matters, Dr. Goodell's main theme may be both stated and defined in his own words, viz.:

"Now, in these days of mental overstrain, nerve-tire, or neurasthenia as it is technically called, is so common a disorder in our over-taught, over-sensitive, and over-sedentary women, that in its successful treatment every physician has an abiding interest. It manifests itself by hysteria, by spinal irritation, and by a crowd of reflex symptoms, among which those of a uterine complexion often overshadow, and indeed outlast all others."

Dr. G. follows this with the naming of the legion of symptoms that bespeak phases of ill health almost as numerous, frequently leading to an apparently hopeless bed-ridden invalidness, the victim being of bad flesh, worse blood, and worst nerves. For his idea of the best management of this last condition, he acknowledges his indebtedness to Dr. S. Weir Mitchell, who details the process in his book, "Fat and Blood, and How to Make Them." In addition to Dr. Mitchell's method, some cases require local uterine treatment and some do not. Dr. Goodell gives three illustrative cases; in one no local treatment, in another local treatment without benefit, and in the third advantageous local treatment throughout the management. The first case was a large-framed girl of twenty, an invalid for five years, and now bed-ridden. She had aches all over, especially severe in the back and over both ovaries; hystero-epileptic fits with frightful screams, retention of urine, uterine tenesmus, leucorrhea, obstinate constipation, and a loss of all appetite. She was put in an upper room, and allowed to see no one but the nurse and physician; was fed on skimmed milk, rubbed (massage), and had electricity applied. At first she could take but little milk, but her ability rapidly

increased in this direction, and new milk was presently substituted for the skimmed. She was cured in forty-five days, having consumed two hundred and eight quarts of milk and one hundred and eighteen eggs. In the beginning she had an occasional anodyne, and during the treatment no other medicine than Trommer's extract of malt, dialysed iron, valerianate of zinc, and at intervals an aperient pill. At her discharge she had gained twenty-two pounds in weight, and her waist had expanded from eighteen inches to twenty-seven. Her health appeared to be fully restored.

The other two cases were married women, older than the first, and while their symptoms were diverse from the first and from each other, they were both wretched almost beyond description; but by "rest, electricity, massage and diet," one was restored to health, and the other rendered able to care for herself. The moral management of these patients was an important factor in their cure, but can here only be thus generally stated. Dr. Goodell's address is full of rich suggestions, and the general practitioner will find in it valuable aid in the management of a troublesome class of cases.

Dr. J. C. Reeve, of Dayton, Ohio, described a "Case of Rupture of the Perineum without Implication of the Vulva," to which he was called ten days after the accident, and which he relieved by three operations, but was not entirely cured when the patient passed out of his hands.

Dr. White, of Buffalo, thought laceration of the perineum ought to be prevented by making a triangular division of it in cases where rupture was impending.

Dr. J. Marion Sims, of New York, was absent in Europe, but furnished a long illustrated essay "On the Surgical Treatment of Stenosis of the Cervix Uteri." He reviews the procedures for the relief of this defect by Simpson, Greenhalgh, Routh, Barnes and himself, and asserts the superior merits of his present method (a modification of Simpson's), which consists of incising the cervix bilaterally, enlarging it with a trivalve dilator, inserting a glass or rubber plug the full length of the cervix, and retaining the plug with a tampon of cot-

ton-wool, soaked in a carbolized saturated solution of alum. The instruments employed are of his own invention, and he describes minutely the manner of using them, and intelligently all the details of the process. This for stenosis of a straight canal.

In anteflexion of the uterus some cases are given of the relief of leucorrhea, dysmenorrhea and sterility, by amputating the posterior lip of the os tincæ; and cases of success in treating the same difficulties by slitting the posterior lip in the median line to the vaginal junction; and then the author dwells long and earnestly on the value of his antero-posterior section of the cervix in many cases of stenosis from anteflexion. Indeed a considerable part of the essay is taken up with a plea to vindicate his claim to originality in this operation, most of his cases and illustrations being devoted to this end.

Speaking of the danger of the incisions of the cervix, Dr. Sims says he has performed the operation nearly a thousand times in twenty-two years, with two deaths—one of these being due to accident arising jointly from imperfect dressing and improper nursing, the other came of the bursting of an abscess of the fallopian tube, existing unrecognized before the operation. In both cases, the immediate cause of death was peritonitis.

Not by its direct statements, but by the whole tone and tenor of this dissertation, one is led to infer that stenosis of the character described is very common, is always attended by dysmenorrhea and sterility, and is always cured by a proper operation, which, when skillfully performed, is certainly safe. This roseate inference would be likely to lead the inexperienced or thoughtless gynecologist astray, if there were not some dimming of the brilliant coloring. The check to this danger is found in the valuable discussion which followed the reading of the paper.

Dr. Barker, of New York, opened the discussion by using fitting terms with which to accord to the author of the essay the very highest position as an original, ingenious, bold and

skillful gynecological surgeon; but adding that this "should not exempt his doctrines and his practices from searching examination and honest criticism." Dr. Barker illustrates the unequal merit accorded to cutting operations in stenosis, by supposing in effect that four gynecologists of equal culture and skill, having equal number of patients in an equal time; statistics show that one will operate on one thousand cases, a second on seven hundred, a third on five hundred, while the fourth will find but two hundred needing that kind of attention. This is a significant statement. He also declares that some excellent men, who formerly operated very frequently, do so now rarely; and, what is decidedly important, he knows of sixteen unpublished deaths from incising the cervix, occurring in New York alone. His words lead one to apprehend that this operation has often been done unnecessarily—that its success has been overrated and its danger underrated. Furthermore, he points out in a rational way how enthusiasts may easily be led astray in these particulars.

Dr. E. Wilson, of Philadelphia, had better results from dilatation than from either Simpson's or Sims's operation.

Dr. Noeggerath, of New York, maintained that the idea of straightening the canal by a cutting operation was untenable; one might enlarge it by such procedure, and this was best done by Peaslee's method, which simply incised the mucous membrane, leaving the parenchymatous structure intact. The habit of gentlemen was to cut the cervix, which gave temporary relief, and which they believed to be a permanent cure, whereas in six months, one, two or three years, the canal had assumed its old form, and reëstablished all the former suffering. The value of this operation had been discussed for over twenty years, and the discussion would continue until the friends of the operation consented to watch for the final condition of their patients and report the result. Dr. N. had a method of his own for treating this disorder, but in not enough cases had sufficient time elapsed to authorize him to present his plan.

Dr. H. P. C. Wilson, of Baltimore, feared the tendency of

the debate was to ostracize the operation. No doubt the operation had been done many times when it should not have been, but he thought there were instances where no other means would effect a cure.

Dr. Lyman, of Boston, did not think much of the operation; preferred dilatation; but hoped Dr. Emmet would give his views of the pathology of these cases.

Dr. Emmet, of New York, was convinced that where the flexure was above the vaginal junction, it indicated trouble elsewhere, and an operation would do no good; and in all cases it is important to determine how far the flexion is due to previous cellulitis, and in such cases not operate.

Fairly interpreted these proceedings would indicate to the young gynecologist that the popularity of the operation of incising the canal of the cervix uteri for stenosis is on the wane, and yet that there may be cases in which it is demanded.

"A Case of Extra Uterine Pregnancy, with Discharge of the Fetal Bones through the Bladder," is reported by James P. White, M. D., of Buffalo, wherein a part of the bones were extracted from the urethra from time to time for over two years—the remaining bones supposed to be encysted about the fundus of the bladder. The patient had three attacks of peritonitis, but for a year had been in good health.

Joseph Taber Johnson, M. D., of Washington, D. C., narrated a "Case of Foot and Head Presentation, with Fracture of the Spine in Utero." The patient was a vigorous woman, who had had two easy labors. This third labor lasted twelve hours, and the child was delivered under chloroform with forceps—the head presenting with the occiput to the right acetabulum, and the left foot in advance of the head, and this relation was maintained until delivery, the force of the pains having fractured the spine in the middle of the back. Although at delivery the mother's pulse was one hundred and forty, and her temperature 101.5°, she made a quick and good recovery. The child was still-born.

Thomas Addis Emmet, M. D., of New York, read a paper entitled "The Necessity for Early Delivery, as demonstrated

by the analysis of one hundred and sixty-one cases of Vesico-Vaginal Fistula." A tabular statement of these one hundred and sixty-one cases is given, showing that one hundred and forty six were cured, nine improved, three not improved, one died, and in two the result was unknown. The table also gives in each of these classes the mode of delivery, the average time in labor, and the time under treatment for the fistula, the number of still born children, condition of bladder during labor, and the time of escape of urine. Dr. Emmet says:

"At the outset I must state that an analysis of these cases establishes the following facts: Instrumental delivery has rarely, if ever, any agency in the production of vesico vaginal fistula. The direct cause is always the delay in delivering after impaction has taken place; while the indirect one, in a large proportion of cases, is a neglect to empty the bladder."

This is certainly strongly stated, and the author points to the medico-legal bearing of the facts he presents.

He analyzes his table to impress the lessons it teaches; an important one being the necessity of an earlier resort to forceps for delivery than has been the custom with accoucheurs.

A lengthy discussion of this paper followed its reading.

Dr. Smith, of Philadelphia, was glad to have Dr. Emmet's statistics in favor of an earlier application of the forceps. In the Philadelphia Lying-in-Charity over ten thousand women have been delivered, mostly attended by medical students, who have been taught to resort to the forceps early, and but one case of vesico vaginal fistula has occurred, and that from a vaginal rupture extending into the bladder.

Dr. D. H. Storer, of Boston:—"I have no doubt that the forceps are of great value in certain cases. . . If the forceps be not applied until impaction of the presenting part has taken place, I agree with the gentleman; but the idea that the forceps is an instrument which must be almost constantly used is, I think, a dangerous one"

Dr. Barker, of New York, warmly espoused the theory of the paper teaching the necessity of attending to the condition of the bladder in protracted labor; and as warmly approved

of the recommendation of an earlier resort to the forceps than had been the habit heretofore of obstetricians.

Dr. Penrose, of Philadelphia, counted the most valuable point in the paper that which taught that the exact time to use the forceps was almost immediately after the head of the child ceased to recede after a pain.

Dr. H P. C. Wilson, of Baltimore, was of the opinion that the forceps should be used when the head ceased to advance, whether it receded or not, on the subsidence of a pain; with his increasing age the more freely he used forceps: its use should be regarded as an accompaniment of labor, not an operation.

Dr. John L. Atlee, of Lancaster, finds that the older he grows the more frequently he applies the forceps.

Dr. White, of Buffalo, announces that statistics show that formerly forceps delivery was once in six hundred cases, and now once in ten cases; and he approved of the change.

Dr. Emmet added a word to say that the bladder must always be emptied before delivery with the forceps; if it could not be done with a catheter, it should be done with an aspirator above the pubes.

Dr. Reeve, of Dayton, Ohio, reported his use of an aspirator as named by Dr. Emmet, and was pleased with it.

Dr. Goodell, of Philadelphia, feared that the frequent use of forceps was too strongly advocated in this debate. Skilled men, like those who had spoken, could use the instrument without harm; but this discussion was to influence the young and inexperienced, and they should be taught caution. Rupture of the cervix and the perineum did occur from the general use of forceps. True, over ten thousand cases of parturition had taken place at the Lying-in-Charity in Philadelphia, under the care of the students, who had been taught the propriety of the early use of the forceps, without an accident from the use of the instrument; but the good result was accounted for by the fact that the students did not operate, but at the first dawn of trouble sent for their accomplished teacher, his friend Dr. Smith.

Dr. Englemann, of St. Louis, feared that Dr. Emmet's paper might lead to erroneous conclusions concerning the use of forceps, unless other statements were made than those already given us.

One readily deduces from Dr. Emmet's paper and the comments it excited, that the sentiment of many prominent obstetricians is in favor of the more frequent use of forceps in tedious and delayed labor, but that this sentiment is not held by all eminent accoucheurs. The truth seems to be that skilled men may use the instrument frequently and safely, where those less qualified had better trust to nature, or what is a reasonable duty, at once call for skilled assistance. It is quite true that vesico vaginal fistula may not be caused by the use of forceps, because the blades of the instrument are carried away from the median line by the fetal head; but this does not prevent them from lacerating other parts to a serious degree when in careless or ignorant hands. Logically, one fails to understand why those who advocate the frequent resort to forceps, asserting that no harm ever comes of their use, should be so minute and emphatic in their directions as to the time and manner of the application of the instrument, and the preliminary precautions and attendant conditions to be observed and enforced.

Two papers follow on the same subject, one by Henry P. C. Wilson, M. D., of Baltimore, entitled "The Hand as a Curette in Post-Partum Hemorrhage;" and the other by R. A. F. Penrose, M. D., Philadelphia, under the head of "The Treatment of Post-Partum Hemorrhage."

Dr. Wilson's is a brief pointed detail of a recent case, wherein after a favorable labor completed in an hour and a half, there was immediately immense hemorrhage threatening the life of his patient. Five times he passed his hand, containing a lump of ice, into the uterus, inducing prompt contraction, but each time followed at once by dilatation and a rush of blood. During the time he was applying the ice he had administered an ounce and a half of Squibb's fluid extract of ergot—six drachms by the mouth, two drachms hypoder-

mically, and half an ounce by the rectum. In this extremity Dr. W. thought of the value of the curette in other hemorrhagic disorders of the womb; and again passing his hand into the flaccid organ, thoroughly raked the placental surface with his finger nails. This brought on feeble contraction, which, however, soon relaxed, and he did a second raking in like manner; and although there was only feeble contraction, not a teaspoonful of blood was lost after the first raking. After forty-five minutes more the after-pains set in, the uterus contracted firmly, there was no further trouble, and the patient made an exceptionally good recovery.

Dr. Penrose, after a deal of circumlocution and a great waste of words, informs that a clean rag or pocket handkerchief dipped in vinegar and carried into a freshly-emptied womb, bleeding through atony, and the vinegar there squeezed from the cloth, acts like magic and never fails. Apparently it makes no difference about the strength of the fluid applied, or what it is composed of, so it is called vinegar, as it is taken from the family supply at hands.

These two papers on post-partum hemorrhage were jointly considered and caused a long discussion, made up mainly of the estimation in which the several speakers held the various measures recommended in our text-books to assist post-partum hemorrhage.

William H. Byford, M. D., of Chicago, contributes a paper on "Dermoid Tumors of the Ovary," describing four of these growths that fell under his operative attention. One tumor contained serum, half a pound of sebaceous fat, having the appearance of yellow butter, and fine brown hair an inch long springing from a patch of dermoid tissue. A second tumor contained bluish serum, yellow fat, and blonde hair eighteen inches long. The third tumor contained ten quarts of bluish serum, several ounces of yellow fat, blonde hair an inch long, many pieces of bone, and more than a hundred imperfect incisor teeth. The fourth tumor was a cyst, having three compartments of about equal dimensions; all filled with fat, no other fluid; all containing bones and teeth—incisors and

molars, crown, enamel and fangs complete; one compartment had in it red hair, another blonde, and the third gray—the patient's hair being dark brown. Dr. Byford followed the detail of these cases with a review of the theories of the origin of dermoid tumors, which was supplemented by remarks of Dr. Noeggerath, of New York, in the same direction.

"A Contribution to the Study of the Treatment of the Acute Parenchymatous Nephritis of Pregnancy," by William L. Richardson, M. D., of Boston. An examination of the urine of one hundred and fifty-six pregnant women admitted to the Boston Lying-in Hospital, showed the presence of albumen in forty-one per cent. This indicates that simple albuminuria need not be regarded as serious. Nevertheless, when the symptoms of acute parenchymatous nephritis are present, it should excite earnest attention, for of these cases under his observation in the last eight years sixty-five per cent. were attended with convulsions. His treatment is not very definitely stated, but appears to have consisted of the administration of saline cathartics, bromide of potassium and chloride, as preventive measures. However, the salient point of the essay seems to be a desire to call attention to the fact, as the author believes it to be, that danger increases with the scantiness of the urine; and if the quantity of urine decreases steadily in spite of treatment, premature labor should be induced, whether threatening symptoms are present or not.

In the discussion of the paper, the speakers considered the points of the paper well taken; but the remarks contained nothing new and striking, unless it was the suggestion of Dr. Thomas, of New York, that pilocarpine was one of the most useful diaphoretics ever introduced into the materia medica.

Samuel C. Busey, M. D., of Washington, D. C., reports a case of "Alternating Anterior and Posterior Version of the Uterus." This might be called a wabbling womb, and Dr. Busey's report of it is valuable, as illustrating a close, scientific study, and the application of ingenious art in the successful management of an unusual and difficult disorder, probably much aggravated by previous bad treatment. A cut of the efficient pessary applied is given.

"Remarks on Gastro-Elytrotomy," by Henry J. Garrigues, M. D., of Brooklyn. The author has sought the literature of this operation, and announces a book soon. He finds the idea suggested by Joerg, a German, in 1806; and in 1821 Ritgen, another German, attempted the operation, but changed it into a Cesarean section, the patient dying of hemorrhage. Without knowledge of his German predecessors, the younger Baudelocque, in France, made two attempts, which he reported in 1844. In one case he also changed the procedure into the Cesarean section, and in the other he completed the operation of gastro-elytrotomy. Both patients died. About 1822, Dr. Physick, of Philadelphia, proposed a modification of the Cesarean section, involving the idea of gastro elytrotomy; and in 1837, Charles Bell gave publicity to a similar thought.

Without any knowledge of what others had done or said, Dr. Thomas, of New York, thought out the operation, and when opportunity offered performed it, and after him Dr. Skene has followed in his footsteps. Each of these gentlemen has performed the operation three times, saving three mothers and four children—a result far in advance of the success of the Cesarean section. Nevertheless the cases are too few to authorize the announcement that gastro-elytrotomy is one of the established obstetric operations, but it presents strict claims for favorable consideration. A supplement to the paper contains illustrations of Ritgen's case.

Albert H. Smith, M. D., of Philadelphia, read a long paper entitled "The Pendulum Leverage of the Obstetric Forceps," and he claims these conclusions:

"First, that pendulum movements are in direct violation of the teachings of nature; second, that they are absolutely useless, so far as any aid to traction is concerned; third, that any virtue they have is in stimulating uterine contractions, which then act independently of them; fourth, that so far from diminishing friction, they increase the mutual pressure of the head and pelvic walls, thus increasing friction; fifth, that they tend to do injury to the pelvic tissues, no matter at what point of the pelvis they are practiced; sixth, that so far from being

specially useful when the head is 'tightly gripped,' to use Dr. Galabin's expression, and the extraction difficult, the greater the difficulty of the case, the greater necessarily is the injury to the tissues."

Dr. Smith admits that all American obstetricians are against him; all British, except Dr. Matthews Duncan; and perhaps all schools, except the Vienna school. Still he has the courage of his convictions, and does battle vigorously for the rule that the direction of traction with obstetric forceps "shall be made steadily in the median line, with no lateral or pendulum motion." This is the practice taught in the Philadelphia Lying-in Hospital from its foundation, by Dr. Warrington, Dr. Ellwood Wilson, and himself. He illustrates by a diagram, but it is easy to make diagrams to suit; and he reasons most earnestly, but his argument is tinged with sophistry, and his premises are not always correct. So far as appears by the record, Dr. Smith did not have any Fellow of the Society to agree with him.

Henry F. Campbell, M. D., of Augusta, Ga., contributes an interesting dissertation on "Rectal Alimentation in the Nausea and Inanition of Pregnancy: Intestinal Inhaustion an Important Factor, and the true solution of its Efficiency." Dr. Campbell refers to a paper on Rectal Alimentation, by Dr. Austin Flint, in the American Practitioner, January, 1878, and to a recent discussion on the same subject in the New York Academy of Medicine, as his sufficient authority for the assumption that "life may be sustained indefinitely solely by rectal introduction of aliments." But while this method of nutrition has been made available in divers other difficulties, it has not been appropriated to the sustentation of pregnant women suffering from gravid nausea. Dr. C. has applied it in this way, and he believes that hereafter it will not be necessary to induce abortion simply because a pregnant woman can not be nourished through the stomach. For food per rectum he gave beef-tea, enriched by the addition of a condensed preparation of meat, to which were occasionally added rice-water, arrow-root, jelly, gruel, blanc-mange, custard, and

the like. Dr. Campbell does not believe the food is digested in the rectum, but that it is carried up through the colon into the small intestines, where it finds juices suitable to convert it into an absorbable and assimilative condition. This transfer of food from the rectum to the small intestines he calls "intestinal inhaustion," and claims originality in its observation, and he relates many well established facts to support his theory, as well as narrates his experiment with a kid as a clinching demonstration.

James P. White, M. D., of Buffalo, reported a case wherein after ovariotomy, because of an irritable stomach, the patient was given a suppository every four hours, containing belladonna, quinia and opium, with seeming good effect, until on the afternoon of the third day, when she had taken thirty-five or forty grains of opium, dangerous narcotism suddenly supervened, from which she was with difficulty rescued.

"Three Cases of Rupture of the Uterus," is a paper presented by Theophilus Parvin, M. D., of Indianapolis. Two of the cases were reported to him by professional friends, and the third he saw in consultation, and delivered by podalic version perhaps six or eight hours after the rupture. The patient died a little more than four days after the accident, the fatal result being due, the doctor believes, to gross neglect and bad management on the part of the nurse. Dr. P. recites some statistics as to the frequency of rupture of the parturient uterus, and briefly refers to the views of the etiology of the accident, of sundry eminent obstetricians. After admitting the value of gastrotomy in certain forms of rupture, he closes with a neat paragraph expressing his adhesion to the creed of Tyler Smith's golden rules for preventing the disaster.

"On the Early Delivery of the Placenta when Previa, with the Relation of a Case of Spontaneous Separation of the Placenta without Hemorrhage," by Isaac E. Taylor, M. D , of New York. The spontaneous separation of the placenta without hemorrhage was in a primipara at about term, the placenta being in a state of thorough fatty degeneration: not two ounces of blood were lost.

Dr. Taylor's paper is largely occupied in defending against all comers his idea that the cervix uteri in pregnant women remains intact until labor sets in, when the contractions of the womb push down the bag of water and the fetal head, and force it open. He has maintained this view for many years, and now presents pictures, facts and arguments to sustain his long time position.

Regarding the treatment of placenta previa, he names seven methods, namely—first, the tampon; second, version; third, partial circular detachment of the placenta; fourth, complete detachment; fifth, lateral detachment; sixth, the forceps; and seventh, the induction of premature labor. Each of these methods is suited to some cases, or parts of some cases, but the author is not satisfactorily clear and definite in laying down the conditions and rules that should guide, by time or circumstances, to the rise of the one or the other of these methods. Certainly he does not appear to fully compass either the nature, the method of application, nor the virtue of the tampon in such cases. In fact the whole paper is a little mixed and muddy. For want of time, this was one of the papers that was read by title only, and consequently was not discussed, which is a subject for regret.

Ely Van De Warker, M. D., of Syracuse, N. Y., has a short essay on the Treatment of Pelvic Indurations and Adhesions. When non-suppurative sequelæ of pelvic cellulitis or peritonitis become painful, it is due to a relighting of inflammation in these deposits. Anodynes have only a limited value in controlling this pain, which must be controlled before cure can be effected. This is best done by rest, swinging in a hammock, and electricity. For the absorption and radical cure of these cases, where nature fails as she sometimes does, the best means are electricity, ammonium chloride, and massage.

A. Reeves Jackson, A. M., M. D., of Chicago, writes "On Some Points in Connection with the Treatment of Sterility." While there is nothing new in Dr. Jackson's paper, there is such a plain and sensible manner of selecting accepted truths,

of arranging and presenting current knowledge, that it has the attractiveness and force of original matter, and will serve as useful a rôle. The general practitioner or inexperienced gynecologist will find something to instruct and much to encourage him in this little essay

The last of the scientific papers presented to the society is a short illustrated report of a case of "Extreme Anteversion and Anteflexion of the Uterus at the full term of Pregnancy," by Isaac E. Taylor, M D., New York. The pendulous belly reached within an inch of the knees when the patient was standing: there was general contraction of the pelvis. When labor came, the uterus was held in place by a stout bandage from the shoulders, and delivery of a large child effected by the forceps. All did well.

Two Fellows of the Society died during the year—E. R. Peaslee, M. D., LL. D., of New York, and Washington L. Atlee, M. D., of Philadelphia. For each the volume contains a full and affectionate obituary memoir; that for the former written by Dr. Fordyce Barker, for the latter by Dr. Thos. M. Drysdale. Each memoir is adorned by a handsome engraving of the distinguished gynecologist whose virtues it records.

A paper submitted to the Council by Nathan Bozeman, M. D., New York, a candidate-elect for Fellowship, is headed the "Mechanism of Retroversion and Prolapsus of the Uterus considered in relation to simple Lacerations of the Cervix Uteri, and their Treatment by Bloody Operations." Dr. B. finds the text for his paper in a contribution to the American Journal of Obstetrics, November, 1874, by Dr. T. A. Emmet, of New York, entitled "Lacerations of the Cervix Uteri as a Frequent and Unrecognized Cause of Disease;" and another communication by the same writer, on the same theme, in the American Practitioner for January, 1877. Dr. Bozeman thinks Dr. Emmet is mistaken in his theory, his facts and his treatment of these lacerations of the cervix uteri; and after a philosophical consideration of the structures and forces involved, details his own treatment, consisting of constitutional invigor-

ation and local support, chiefly by a special steel wire pessary of his own suggestion.

The volume is completed by an index of gynecological and obstetric literature of all countries for 1877, occupying forty-six pages.

The book is handsomely printed on tinted paper, and is remarkably free from typographical imperfections. As a whole, the Fellows of the American Gynecological Society may well feel comfortable over both matter and style of the third volume of their Transactions. J. F. H.

The Advantages and Accidents of Artificial Anæsthesia—A Manual of Anæsthetic Agents and their Employment in the Treatment of Disease By LAURENCE TURNBULL, M. D., Ph. G., Aural Surgeon to Jefferson Medical College, etc. Second edition, revised and enlarged, with twenty-seven illustrations. Philadelphia: Lindsay and Blakiston. 8vo., pp. 322.

The rapid sale of a large edition of this work in a year, proves it to have been a book that was needed. In some of our larger hospitals the use of chloroform has been prohibited, and to busy practitioners, away from medical centers, the question comes, what anesthetic shall we use? After a careful reading of this book, we think the practitioner will arrive at the same conclusion as the author, namely, that for minor operations hydrobromic ether is most satisfactory, for the usual dental operations nitrous oxide gas is safest, and for dangerous and protracted operations the safest and best anesthetic is the pure ether. The author states that the danger to be avoided in anesthesia by ether is over-inebriation, but that ether always gives timely warning. He quotes the statement that the dangers from chloroform are not averted by its admixture with ether in any proportion; and that the combination of these two agents can not be too strongly denounced as a treacherous compound. The former statement we can not fully indorse, for while it is probably best to give these anesthetics separately, yet we have seen a depressed heart stimulated

by mixing ether with chloroform. In giving ether vomiting rarely occurs when the patient has abstained from food and liquids for six hours beforehand. In Philadelphia ether has been administered about 34,980 times from 1846 to 1878, without a single primary death and only one secondary death. Every doctor knows that chloroform depresses the heart's action and ether stimulates it, and Dr. Turnbull gives a sphygmographic tracing to show this fact.

There is presented a table of eighteen deaths from ether, the deductions from which as to the cause of death are, first, that the fatal effects of ether do not depend upon any directly poisonous properties of its own; second, that the cause of death was asphyxia. There is a table also of one hundred and sixty deaths from chloroform, which, added to two hundred and ten cases previously reported, make a total of three hundred and seventy. The causes of death in these cases were collapse, shock, syncope, asphyxia, paralysis of the heart and chloroform-poisoning.

Formulæ are given for the internal use of the various anesthetics and for their local application. Among the latter, the ether spray over the abdominal wall for the control of post partum hemorrhage, and in chorea "a jet or hand spray of sulphuric ether will relieve the most violent spasmodic or convulsive attack of chorea, with the subsequent use of Fowler's solution, five to ten drops three times a day in water, and occasional application of the galvanic current to the spine."

Cases of threatened death from chloroform resuscitated by the use of nitrite of amyl are given, also cases in which this antidote utterly failed, but the preponderance of evidence is in favor of its use.

In regard to the use of chloroform in natural labor, the tendency, as given in the book, is to its use in small quantities in the second stage, although Playfair thinks it favors post partum hemorrhage, and that chloral in fifteen grain dose acts far better, and does not lessen the strength of the contraction.

There is handy index for ready reference completing the manual. A. M.

FOREIGN CORRESPONDENCE—OUR LONDON LETTER.

LONDON, September 15, 1879.

MY DEAR YANDELL: The sun is shining—no, not brightly, but it is shining, and has been doing so, more or less, the last three days, which represent almost all the summer we have had this year. Deluged with water, drowned out; our wheat crop a terrible failure, potatoes done for, we must look to foreign supplies of food; while our farmers must just bear their ruin as manfully as they can. It is very serious; and the country doctor all over Great Britain will have to share with the farmer in his embarrassment. Even barley and hops, for the national beverage without which we could not exist—in spite of Sir Wilfred Lawson and the Alliance—are wanting this year; and we must look to foreign materials even for our choicest Burton. Our requirements in the way of food ought to be beneficial to your farmers, so that it is an ill-wind that blows nobody good. But our farmers do not like your American weather-prophecies, especially since they perceive that their ruin is to the advantage of American farmers. The present season will put hundreds of the old-fashioned farmers "out of their misery;" and those who can stand the loss will know better than grow wheat in England any longer against foreign competition. I know, my dear Yandell, this is not quite to the point; but our minds in Great Britain at present are occupied—yes, and exercised too—on this subject of the failure of our crops, and the continued fall in wages, and what our poor are to live on next winter.

The great medical event since my last letter has been the British Medical Association meeting, which took place this year at Cork. Doubtless your brother will have given some account of the social arrangements, and the kind of a time they had amidst Irish hospitality; so I will confine my remarks to the work done.

Prof. Hudson, of Dublin, led off with the address on Medicine, and took for his subject "Laënnec: his Labors and their Influence on Medicine." He pointed out how Laënnec developed mediate auscultation, by which our modern method of careful examination of the chest was rendered practicable. He drew attention to the fact that Laënnec did not himself overestimate the importance of physical signs, though some of his followers have done so: he

repeatedly urges the value and necessity of the study of rational symptoms. He then referred to Laënnec's views on tubercle, which have been found to be in parts erroneous. A leader in the British Medical Journal says, in reference to this subject. "Great as Laënnec was, both as a pathologist and a clinicist, his fame will always depend upon his clinical investigations. The French school have recently attempted to rehabilitate Laënnec's pathology of tubercle; and there is no doubt that, so far as phthisis is concerned, the investigations of recent years have shown that there are no histological characters enabling us to say that this is tubercular and this is pneumonic phthisis. As Dr. Green has shown, there is absolutely no change in phthisical lungs which is distinct from what may be seen in various chronic inflammations. Caseation may be fully admitted to be a change in which inflammations in strumous subjects are prone to terminate; and were there no tubercle but that seen in phthisis, there would be little difficulty." That there is acute tuberculosis—a disease *per se*—must, however, be admitted. Professor Hudson recognized the importance of bearing the inflammatory origin of phthisis in mind in treatment, both as to "relapses, which ensue from exposure to cold or other acts of imprudence during the progress of the disease," and the treatment of the early stages. He says, "I have seen several cases in which the life of the patient was prolonged for years by the vigorous treatment of an attack of pneumonia or pleuritis, or bronchitis occurring in a more or less advanced stage of the disease; while as regards the earlier stages, it has been my practice, in all cases in which the exciting cause was cold and the symptoms and physical signs those of any form of inflammation or congestion, to commence by the employment of such measures as moderate local depletion, counter-irritants, and the free administration of the iodide of potassium, and bicarbonate of potass., conjoined with sedatives. I could cite not a few cases in which this treatment has apparently averted the disease." He however forgot, or anyhow omitted to point out, how often local depletion, of the best and most effective character, is brought about by hemoptysis spontaneously set up; and which gives such relief in the congestion of commencing lung mischief—call it by what name we will.

He then considered Laënnec's work in relation to the diseases of the heart, and especially "fatty degeneration." Laënnec described

fatty degeneration correctly, and discriminated betwixt it and fatty infiltration, though to Quain belongs the merit of having established the two forms conclusively. The subject has been followed out by Stokes, Walshe, Hayden, and Fothergill ("who gives a masterly description of the general symptoms," he says), until the whole matter is now fairly understood.

William Savory, F. R. S., Surgeon to St. Bartholomew's Hospital, gave the address on Surgery, and chose as his topic "The Prevention of Blood-Poisoning in the Practice of Surgery." He thought the chief triumph of this era of surgery is the successful war it has waged with blood-poisoning in all its various forms. He said of bacteria that every one knows how they are prone to abound when putrefaction and kindred changes occur. For the most part their presence may be regarded as the signal that such changes are in progress; but the exact relation they hold to such changes is at present with many a vexed question. He said:—"We do know that when fluids so changed by them find an entrance from without, they are prone to provoke grave mischief. But we also know that such fluids, potent for the gravest mischief, may be produced within the body, deep among the tissues, far away from any chance of direct communication with the air, and this without previous wound or injury of any kind." He then discussed the subject of how it is that all wounds not treated antiseptically do not go to the bad. He said:—"All wounds except the most recent, when tolerably healthy, are covered, as we all know very well, by a newly-formed delicate structure, sometimes called granulation tissues—sometimes presenting other but kindred forms; but which, in any case, constitutes a continuous layer interposed between the blood and whatever may be on the surface: and it seems to be pretty clear that this animal membrane has, like similar structures of the class, the property of separation; that it has the power of allowing of the passage of certain substances and rejecting others, and that upon this simple action of dialysis health and life very often depend. It remains then to inquire under what conditions the poison can gain entrance to the blood. First of all, this mischief is least likely to happen in healthy wounds during the process of repair; and when it does occur, it is either in a wound unhealthy in character or flagging in action, or in one so recent, or in which the process of repair has been so delayed, that little or no new and healthy tissue has been produced on the

surface. In other words, when the newly-formed tissue is healthy and entire, it is tolerably impregnable, and whatever interferes with its integrity gives the opportunity for mischief. I say the mischief is less likely to happen in proportion as the wound is healthy and the repair is rapid; but exceptions to this we know to occur: and it is reasonable to suppose, in some cases at least it has been almost demonstrated, if in some obscure corner reparative action has not failed, that from some violence or accidental disturbance or other cause, the continuity of the new structure has been broken or its integrity somehow impaired, and so the poison has passed in." Once it was thought all mischief arose from within; then the truth began to dawn that the actual poison was derived from without; and since then antiseptic surgery has taken up its position."

He then proceeded to describe how he would treat a wound, as an amputation of the thigh, or excision of the breast. "Having carefully arrested all hemorrhage, using most probably the carbolized catgut ligature, and having gently removed any particles of blood-clot that may have lodged on the surface, employing only clean water or sponges just rinsed out of it, I should, without any other interference with the surface of the wound, bring the edges together, adapting these as nicely as possible with silver wire sutures. I should not in this way attempt to close the wound completely, but I should leave spaces between the sutures, perhaps from one to two inches long. Then, over the course of the wound, and for some distance on each side of it, I should place a layer of folded lint, which had been previously well soaked in olive or almond oil containing one part in about fifty of carbolic acid. Over this again I should place two or more layers of dry lint, either with or without cotton-wool; so arranging this as, by gentle and equable pressure, to secure without any violence, as far as practicable, the accurate adaptation of the surfaces of the wound throughout, avoiding thus any considerable cavity in the interior. I should secure all this by strapping or bandage, or both, so adjusting these that they may hereafter be removed with the least disturbance. I should place the patient and the wound in the most comfortable position possible, having especial care to the fact that fluids, as they form, may flow outwards. Thus, for instance, after excision of the breast I have, for some time past, placed the patient, not on her back, but on the opposite side, so as to make the inner angle of the wound the most

dependent part of it. I am convinced that this assists greatly in promoting speedy and satisfactory repair. It is much better for fluid to escape at the inner than the outer angle, and this more especially when the axilla has been disturbed by the removal of glands. The cellular tissue is so very much less abundant and less loose towards the sternum, that the chance of infiltration of it by fluid is very much less. As a rule, perhaps, I do not disturb this arrangement for forty-eight hours; although very often I change the dressing and inspect the wound after twenty-four. I am guided in this matter of time by the state of the patient—whether spare or full-bodied, her sense of local and general comfort, freedom from or complaint of pain, and the season or temperature. But whenever I am in any doubt I change the dressing; these, then, are removed with the utmost gentleness, and the state of the wound carefully inspected. Especially is attention directed to whether there is any tendency to the lodgment of fluid; whether that which forms can escape freely; whether there is much tension in the edges. I am bold enough to think that a surgeon who understands his business can tell, without painful handling, whether the surfaces of the wound are fairly in contact, or whether there is any tendency to the accumulation of fluid separating them. But if any doubt arise on this important point, a perfectly clean probe or director, lightly applied to some portion of the wound, will solve it, and secure ample vent; if at all necessary I should not hesitate to remove one or two or more sutures. If the wound presented no other evidence than that of satisfactory repair, I should dress it as before, and proceed in this fashion, dressing and examining it daily or less frequently, according to circumstances. But if at the first dressing, or at any time afterwards, the discharge became at all profuse, or the surfaces did not remain in contact, or there were much tension or a blush at the edges, I should forthwith substitute a bread-and-water poultice for the previous dressing, and probably continue to employ this until at least the deeper portion of the wound had closed. When I dressed the wound, I should wash it probably from the first with tepid water, perhaps containing some permanganate of potash in the form of Condy's fluid, or other potent antiseptic of the least irritating kind. I should accomplish this washing out, if I thought fit, by the use of a syringe, avoiding contact of sponges or other substances with the wound. I aim here at the utmost possible cleanliness, having at the

same time due regard to the avoidance of any unnecessary disturbance, that the process of repair be not interrupted; and withal, I endeavor, by means I need not indicate, to secure for my patient the most complete rest and the purest air." (How the late Prof. J. Hughes Bennett would have declaimed against these "perhaps" and "probablys!")

He then inveighed against the present excessive use of drainage-tubes, holding that in many cases care in securing a free outflow from the most dependent part of a wound is of most value. Drainage-tubes are, he holds, "foreign bodies in a wound. They act, of course, as foreign bodies in almost all circumstances do; they irritate, they provoke suppuration and the formation of fluids. Those who are accustomed to witness with complacency the escape of fluid along drainage-tubes, hardly reflect that the drainage-tube has been a cause—perhaps the prime cause—of the formation of the fluid which flows out. When I see these tubes moved to and fro in a wound with the escape of pus, I am forcibly reminded of what I have often seen in former years, the action of setons; the drainage-tube is in fact a seton. Even when they are retained only for a short time, not long enough to produce further mischief, they are fatal to the chance of direct union of a wound. And is this, the best of all results, to be now altogether given up as a visionary idea? Is union by the first intention to become a thing of the past?—(he trenchantly asks.) When I see for example a fatty tumor, small or of moderate size, removed under the skin, and then the edges of the wound stitched closely together over a drainage-tube lodged throughout its length, it seems to me idle to talk of principles of surgery. That such wounds do at length close in spite of this treatment, I know; but I think I know also that they will heal more quickly and kindly, directly without disturbance, if they are simply closed in the way to which I have already alluded." Under certain circumstances drainage-tubes are very useful, he admits.

He has a good word for his old friend, the bread-poultice. He says:—"Its absolute and relative value in surgery can be determined only by experience; and if the surgeons who condemn it have done so only after a fair trial, then all I can say is that their experience on this subject is very different from mine. Having many years ago, like I suppose most surgeons at one time or another, been prejudiced against poultices (for if not skillfully made they are ugly

and clumsy things), I have more than once cast them aside in favor of some other application; but again and again I have been driven back to their use by the plain fact, as it appears to me, that they fulfill certain conditions better than any of their rivals. I do not undertake to explain how they are excellent. I find certain qualities possessed by them in an eminent degree, but to what precise extent these are instrumental to the result I can not say. A well made bread-poultice (which I make bold to suspect some of you have never seen), preserves ample moisture and equable warmth; it is everywhere very soft, and adapts itself with singular uniformity to all irregularities of surface. In my experience this homely article far more frequently draws from the patient the word 'comfort,' than any other form of dressing. 'Yes, that is comfortable,' is a familiar expression after the application of a poultice. Poultices of course, like all other applications, are liable to abuse; and I think that years ago they lost favor chiefly on account of the reckless way as mere routine in which they were employed, the faulty manner in which they were too often prepared, and the length of time during which they were allowed to remain unchanged. But I venture to repeat that, when applied in appropriate cases, they give, so far as my experience goes, more comfort to the patient and satisfaction to the surgeon than any other substance. Moreover, in certain cases of unhealthy wounds and of foul discharges, they become a most convenient vehicle for the use of charcoal and other agents; and I for one, in spite of all our present proud array of antiseptics, should be sorry to lose altogether the help of the old-fashioned charcoal-poultice." So much for Mr. Savory.

In his address delivered at the opening of the Physiological Section, Mr. Henry Power said something very much to the point, which I shall quote:—"No doubt can be entertained that a better and more thorough knowledge of physiology should be possessed by the younger members of the profession than at present prevails. In my opinion, and I have had large opportunities of observation, I think that, considering the time at the disposal of the student, too many anatomical details are required in most examinations, whilst physiological knowledge is held in too light esteem. It has been argued that the study of anatomy is not only essential for the due and safe practice of the profession, but that it is an important means of education; that it is the one thing which is properly taught—the

one thing that is well known in the preparation for the profession. Whilst admitting its value in this respect, and acknowledging the difficulty of drawing a hard and fast line defining what should and should not be known, I can not but think that the candidates for most of our examinations are asked points in anatomy which when known are utterly valueless; whilst if the same time and labor had been bestowed npon physiology, valuable information of a practical nature would have been acquired. Many candidates for our ordinary examinations are able to describe the course and relations of minute branches of nerves and arteries, a knowledge of which they will most probably never have occasion to apply, or if they have, they will have forgotten them; whilst, in regard to such important points as the nature and digestibility of different kinds of foods, or the more important phenomena of the functions of the circulation and respiration, they can give no intelligible account. It is, indeed, often objected that the whole subject of physiology is in such a state of fusion and transformation, that what was regarded as established on sure and irrefutable grounds one day is overthrown the next, to be replaced by some equally transitory theory; and the inference drawn is, that it is of little use to learn any physiology at all. The frequent repetition of this by those who should know better, has led to disastrous consequences: and I am convinced that a considerable number of men present themselves for examination who have paid little or no attention either to the lectures or to the demonstrations which are now excellently given at most of the schools; and have done little more than commit to memory the composition of such of the fluids and solids of the body as they think are likely to be asked, and which they, as a result, confuse in a very remarkable manner." The student himself often feels acutely the uselessness of the knowledge which he is compelled to possess on anatomical minutiæ before appearing at an examination table: and complains that what he has to learn is of no use to him in practice. The student would much more willingly study, if the subject of his study only bore on practice: he knows he is getting a stone when he asks for bread. But of this subject more anon.

This cold summer has kept down the death-rate, especially as to the deaths from hot weather maladies. A general practitioner writing to me the other day said, "What prospect is there for me with the death-rate at 17.1 per thousand?"

Clinic of the Month.

TREATMENT OF DELIRIUM TREMENS.—In "Flint's Clinical Medicine," just published, we find the following on the above subject:—The development of delirium tremens, if the premonitions be recognized, may probably often be prevented by either a full opiate, one of the bromides or the hydrate of chloral. These remedies act by overcoming the sleeplessness, which is undoubtedly an essential factor in developing the disease. The importance of watching for the premonitions, especially in surgical and medical cases, is evident.

The important remedies are opium, alcohol in some form, chloroform by inhalation, and the hydrate of chloral, the bromides, digitalis and antimony. Opium given in large and enormous doses, as was formerly the practice, was conclusively shown by Ware to be pernicious. Sleep is the desired object, but narcosis is not a substitute therefor. It is hazardous to induce the latter. But an opiate, in small or moderate doses, is often useful. This remedy should be tried.

A quarter of a grain of the sulphate of morphia every four or six hours, or an equivalent of codeia or some other preparation, is the safe limitation as regards dose and intervals. Alcohol is relied upon by many, but opposed by some on the ground of moral considerations. The latter are of little weight. The patient will not be likely to resume the habit which has caused the disease any the more because alcohol may have conduced to the recovery. In the treatment alcohol should be given in moderate quantity, and suspended when sleep occurs. It is indicated especially when the patient is much enfeebled, and the pulse denotes cardiac weakness. The inhalation of chloroform may be tried, especially when the delusions induce extreme terror or violence of delirium.

It sometimes is useful, but more frequently it fails. The attempt to produce anesthesia is often resisted by the patient, and the violence of the delirium is thereby increased. The hydrate of chloral is more easily employed. It sometimes acts like a charm. Proper precautions are to be observed in the use of this remedy. The bromides may be given with much less reserve. They should be fairly tried. Their effect is sometimes excellent and sometimes *nil.* Digitalis is in some cases notably efficacious; it is indicated especially when the heart's action is frequent and weak. It is unnecessary to give this remedy in doses of from half an ounce to an ounce of the tincture, as may be done with safety; half an ounce of the infusion every two or three hours will secure all the benefit to be obtained from it. Antimony is suited to a certain class of cases, namely, those in which the symptoms are violent, and the patient robust, and the action of the heart strong. As a sedative remedy, it is notably effective in some of these cases. It should be carried to the extent of producing nausea. It may be advantageously combined with an opiate.

Good nursing has much to do with the speedy success of treatment. Attendants who have tact in calming the patient, a quiet room, avoidance of all excitement, sponging the face, head and body, the warm bath, the wet pack, or sometimes, if the patient consent, even the shower bath, contribute to the object of treatment—namely, sleep. Alimentation is highly important. As much nutritious food should be given as can be taken and digested. Tonic remedies, a nutritious diet, and hygienic measures to invigorate body and mind, will not only expedite recovery, but render much aid in preventing a return to the alcoholic habit.

Nitrite of Amyl.—The exact amount of vascular dilatation produced in frogs by the inhalation of nitrite of amyl has been carefully investigated at Heidelberg by Dr. Gaspey, who has detailed the observations in Virchow's *Archiv.* On the uninjured tongue of the frog the dilatation occurred immediately in both arteries and veins, and increased during the first

two minutes. The duration of the dilatation depended upon the duration of the inhalation; if the latter was continued for two minutes, the dilatation lasted from ten to fifteen minutes. The amount of dilatation was at least one-third of the original diameter of the vessel. The rapidity of the blood-current remained about the same; in the first movement after dilatation it appeared somewhat quickened, but always quickly returned to the normal. In order to ascertain whether the nitrite of amyl acts upon vessels which are already dilated by some other means, irrigation of the frog's tongue with a solution of salt was employed, which is known to cause dilatation of the vessels and retardation of the blood-current. Amyl nitrite was found to still produce its effect, although in less degree—amounting to about one-fifth of the original size of the vessel. Experiments on the effect of the amyl in distant parts showed that the changes in the web of the frog's foot differed somewhat from those observed in the tongue. The dilatation occurred in about the same time, but was slighter. There was an immediate but very transient increase in the rapidity of the blood-currents, followed by a distinct retardation. Another point investigated was the effect of the amyl on tissues in which inflammation is going on. Its action on an inflamed tongue was found to be essentially the same as on the uninjured tongue, thus confirming an interesting observation of Mr. Talfourd Jones that hemorrhage after injury may be increased by the amyl. Other observations on the frog's mesentery showed that the process of inflammation was not in the least interfered with by the inhalation. The migration of the white corpuscles was not lessened. It is known, however, by the experiments of Thorma and Appen, that as a rule, whatever accelerates the blood-current lessens migration, and whatever retards the blood-current favors migration. It seems, therefore, that the influence of amyl nitrite on the inflammatory process may be different according to the position of the part, since retardation of the current was observed in the frog's foot and was not observed in the tongue. (The Lancet.)

CURARE IN HYDROPHOBIA.—Dr. Offenburg, of Munster, has lately treated with curare a woman who had been bitten by a mad dog. He did not confine himself to the usual small doses, but injected about two decigrams of curare under her skin in the course of five hours. The patient was in a terrible state, and seemed on the point of being suffocated when the injections were made. After the first injection the convulsion ceased suddenly. This was owing to the power which curare has of paralyzing motion. After a short pause, however, the convulsions began again, and several additional injections had to be made. At last the effects of the curare became so powerful that the patient was in danger of dying of paralysis of the heart and the respiratory muscles, and could only be saved by artificial respiration. She then fell into a state of exhaustion and weakness, from which she recovered after a time, and became quite well. (Medical and Surgical Reporter.)

A PLEASANT REMEDY FOR TOOTHACHE.—Dr. T. C. Osborn was applied to by a woman for relief from a severe toothache. He says:—"As there was no remedy at hand, I was on the point of telling her to call later at my office, or go to a dentist, when it occurred to my memory that there was in the house a vial of compound tincture of benzoin, which I had been using upon a young mother as a protection against sore nipples. After cleansing the decayed tooth, I saturated a pledget of cotton lint with the tincture, and packed it well into the cavity, hoping this would suffice for the time; and bidding her come back in two or three hours if she was not relieved. I was turning away, when she remarked that it might not be necessary perhaps, as the pain was already gone. But when I arrived at my office there were two other patients awaiting me with the same affliction, and I determined by way of experiment to use the same remedy. To my agreeable surprise both patients declared themselves relieved. During the winter a number of similar cases applied, and were instantly relieved by the same treatment, all expressing much satisfaction with the remedy." (N. Y. Med. and Surg. Brief.)

Notes and Queries.

MEDICAL COLLEGES IN INDIANA.—A second medical college has recently been organized and is in operation in Indianapolis. A little more than a year ago Indianapolis had two medical colleges. Then in compliance with the wishes of many, possibly a majority, of the Indianapolis physicians, the two were made one by the active efforts of three or four excellent medical gentlemen of the city. That curious piece of mosaic, the Medical College of Indiana, was thus constructed; there were so many pieces, and therefore there must be so many places, no matter as to the size, color, or quality of the pieces, or the harmony of the whole. At least one of the gentlemen engaged in this constructive metamorphosis, believing their plans so wise, declared that no other medical college could be started in Indianapolis, at least for a few years. But they builded worse than they knew. In a year another medical college—of more curious mosaic still—is started in Indianapolis, its commencement and possible continuance being in part due to the mistakes made in the original organization of the Medical College of Indiana, to some mistakes made by the College itself and some members of its Faculty—mistakes we may one day have to point out in our own vindication. But we now pass from this topic.

Why should not Indianapolis have two medical colleges, or even three or four, when Fort Wayne has two! Two and two are four, and the Evansville school added, will give us a total of five Indiana medical schools. Surely five ought to be enough to furnish places for ambitious teachers, to work up all the Indiana material suitable for doctors, and to supply the wants of the people!

We recognize in the new school at Indianapolis, as well as

in the one at Fort Wayne, some gentlemen of decided professional ability, and who will doubtless prove able teachers. Such men as Drs. Eastman and Smythe, for example, are too well known to our readers to require any endorsement of their teaching ability. But doctors away from these great centers of medical light and learning will ask themselves, if not others, how much is the profession at large benefited by this multiplication of medical schools? The truth is that outside of the little circles of immediate friends and supporters of these schools, the mass of the profession does not care a rush whether they all prosper and wax fat, or whether they repeat the drama of the Kilkenny cats, in comparison with the intense interest it feels in the subject of medical legislation. Let that legislation be such as will take from all colleges the right of granting diplomas, and it is a matter of indifference to the profession whether this state has one college or none, five or fifty.

A divorce between teaching medicine and the right to practice medicine, this journal advocated many years ago. It is one of the essential points in medical legislation. Such divorce obtained, and an honorable rivalry will exist among medical teachers, to make thorough students instead of to get large classes—students who will pass with honor the rigid ordeal of a licensing board. Without some check of this sort the multiplication of medical schools multiplies evils to the profession. It increases the number of medical students, and thus still further crowds a profession already overcrowded; it tends to lower the standard of professional qualifications, and does lower the honors, the rewards and the dignity of professional life. Will not the earnest strife for students, apparently rendered inevitable by this increase of schools, be followed by an indecent, base struggle for patients? Hunger makes even the cowardly wolf courageous; and it may make cowardly men bold, defiant of just laws and all rules of honor. A man steals a little personal property, and upon detection goes to the penitentiary. But a doctor may steal patients—steal them by false promises and lying assumptions, steal

them by sneers at and slanders of his fellow-practitioners, steal them by an adroit use of his connection with some political, religious or social organization, or by other means not less artful than dishonorable—and he does not go to the penitentiary, or even to Coventry, where every honorable gentleman in the profession ought to consign him until he repents and reforms.

That a remedy for some of the evils now afflicting the profession is to be found in medical legislation, we do not doubt. But medical legislation ought to secure some control in the matter of medical teaching to state societies. Medical schools and medical teachers must be responsible in some way to the organized body of the profession.

In concluding this note, we express our regret that neither of the recently organized schools has had the wisdom to adopt the three years' course of instruction. The time is ripe for such an advance, and the profession would give it a hearty approval. Bellevue promises to follow next year the footsteps of Harvard and the University of Pennsylvania. But how much easier it would be for a college just commencing to adopt the plan, in full faith that the right must win in the long run, however discouraging the outset might be!

CHURCHILL'S TINCTURE OF IODINE.—Dr. E. D. Laughlin, of Orleans, Ind., calls our attention to the following formula for the above tincture in the Hospital Gazette, May 24, 1879:

℞	Iodin.,	ʒ j
	Potass. iodid.,	ʒ ij
	Aquæ,	f ʒ ss

He asks whether this is correct, or the formula which was given in this journal, November, 1877, which is:

℞	Iodin. pur.,	ʒ ijss
	Iodid. potass.,	ʒ ss
	Spt. rectificat.,	f ʒ xij
	Alcohol,	ʒ iv

The latter is the correct formula, as given in the fifth edition of Churchill on Diseases of Women.

DR. HIBBERD'S CIRCULAR.—Dr. J. F. Hibberd, of Richmond, Ind., has issued an address to the members of the Indiana State Medical Society, upon the subject of medical legislation. The Doctor was chairman of the committee appointed by the state society to procure legislation upon the Practice of Medicine, Drs. Helms and Hobbs being his associates. Dr. Hibberd prepared a bill which was presented to, but never discussed by, the legislature. The legislature, however, did pass a bill upon the subject—a bill originally prepared, introduced and earnestly advocated by Dr. Edwins, a representative from Madison county. The bill, however, was vetoed by the Governor, and then failed to pass over that veto. In Dr. Hibberd's address he introduces this bill, presenting several criticisms upon it, and asserting that its veto was right, while commending the general purposes of the bill. He then presents a syllabus of the other bill, and shows in what respects it differs from the Edwins bill.

Dr. Hibberd makes the following suggestions at the close of his address:

To conclude, I think it would be best for county societies, in the consideration of this subject, to have at least three propositions before them, viz.:

First. Is it good policy to have any law in Indiana regulating the practice of medicine?

Second. The syllabus of the Edwins bill.

Third. The other syllabus herein presented. If a majority of any society should decide that it was best not to have a law of the kind, still the society ought to determine what kind of a law they prefer if one is to be made, because a majority of other societies may vote to have a law; and if one is to be made, it is desirable that all should indicate what kind of a law they prefer.

I should like to have returns from each society, distinctly stating how many voted for, and how many against, the first proposition, how many for and against the second and third propositions; and how many for and against any other proposition concerning the same matter that may be before the society.

These returns should be in my hands as early as practicable, not later certainly than January, 1880; and those not in hand by the first of April may fail to be incorporated in the statistical report I desire to make to the State Society in May.

The address of Dr. Hibberd is timely and wise, and can not fail to meet the general approbation of the profession. It is to be hoped that county societies will act promptly upon the propositions presented. Let the profession of the state be earnest and united in the support of some definite medical legislation, and success is certain.

GALVANISM IN ACUTE SCIATICA.—Dr. E. L. Larkins, Terre Haute, Ind., sends us this report narrating a cure of sciatica by galvanism:

In November of last year I was called to see John L., who was suffering from acute sciatica of the right leg. He had been confined to his bed for three or four weeks previous to my first visit. He had passed through the hands of several physicians without obtaining any relief. He had used so much opium in the different forms that I could not convince him of anything except what *he* conceived to be right, so seriously had the narcotic affected him.

I put the patient upon quinia, morphia, and ext. aconite; but after due trial abandoned them. I then put him upon wine of colchicum seed, gradually increasing the dose until the physiological effect was produced, with relief of pain for a short time. I continued the remedy for some time, but found it of no avail. I used morphia subcutaneously for relief in exacerbations of pain, usually morning and evening. I then tried morphia by injecting it into the muscular substance. Subsequently I used a solution of morphia and atropia; no permanent relief. Counter-irritation was resorted to, but without relief.

Having tried the various remedies recommended, including large doses of spirits of turpentine, and obtaining no apparent benefit, I resolved to try electricity. Accordingly I applied the galvanic current, passing it from above downward; instant relief followed the first application. The pain returned next day, but nothing to compare to the former suffering. After three applications of the electricity, entire and permanent relief followed, nor has there been the slightest evidence of its

return since. Warmth returned in a few hours to the entire leg, and the patient was enabled in a few days to be up and around the house. I directed him to apply the electricity two or three times a week for some time. Motion returned, and in a few weeks he was able to come to the office.

After the application of the electricity, I had some trouble in breaking up the desire for narcotics. When the opium was abandoned sleep seemed to have fled, and the wandering pains of the opium-eater racked his body. By exercise, good food and tonics, the bad effects of the drug were overcome.

I do not know that the electricity cured the patient, but the evidence is in its favor.

Hypodermic Injection of Morphia.—Dr. H. H. Kane, of New York City, who has for some time past been collecting statistics on the hypodermic injection of morphia, will consider it a favor if members of the profession having had experience in the use of this instrument, will answer the following questions:—1. What is your usual dose? 2. Do you use it alone or with atropia? 3. What is the largest amount you have ever given at one time? 4. Have you had any inflammation or abscess at the point of puncture? 5. Have you had any deaths or accidents thus produced? 6. Do you know of any cases of the opium-habit from the use of this instrument?

In case of death, please give the results of the autopsy, if any was held. Any reference to journal or other literature on this subject will be thankfully received. All communications will be considered strictly confidential, the author's name not being used, unless permission to that effect is freely given. Address all communications to Dr. H. H. Kane, 366 Bleecker street, New York.

Lectures on Diseases of the Skin.—Dr. Bulkley will give a third course of Lectures on Diseases of the Skin in the Pathological Amphitheatre of the New York Hospital, 7 West 15th street, Wednesday afternoons from half past two to half past three o'clock, commencing Wednesday, October 8, 1879.